		•	- For Amend Item 21	State of Marylan per dvr., go					-	ene	3 - 00
	Physici /Medic	_	1. Decedent's Name (First, Middle, Last) John Vincen	t Wills So				2. C	Date of Death	Day 11-Year - 11-2009	3. Time of Death /:45 PM
	Examir Funeral Director	er	5. Social Security Number 6. Sex 12/7-20-6850			4b. City, Town, of Run Rd If Under 1 Year Months Days	Bel Air	Hrs. 8. D	21015 Date of Birth Month, Day, Y 7-27-1	Harford 9. Birth 926 Balt	place (State or Foreign intry)
	ith the Maryland or 28e-f show	Director	Usual Residence of Decedent 10a. State 10b. County Mayland Harford		y. Town or Lo						10d. Inside City Limits 1 Yes 2 No
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other treumetic event, the Medical Evant far must be notified at ance.	by Funeral	10e. Street and Number 724 Fox Bow 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Amed Forces? 1 1 Yes 2 — No If Yes, Give Year or Dates: WW		Vas Decedent of If Yes, specify Cub		? (Specify Puerto Ricar		14. Race - Amer Black, White	ican Indian,
121215-0036	filed within 72 ho Hygiene. Ither than "netur	Completed	15. Decedent's Educa (Specify only highest grade) Elementary/Secondary (0-12)	ation	16a. Deced	dent's Usual Occul kind of work done DO NOT use retire	during most of			Pharmace iden Sumame)	. 1
Maryland	2 should be filed within and Mental Hygiene. Is marked other then eumetic event, the Mental Barket	To Be	17. Father's Name (First, Middle, Last) Rober 19a. Informant's Name/Relationship (Type)	+ F. Wills	19b. Mailir	ng Address (Street	Luc	YB	allado	arsch City or Town, State, Z	ip Code)
altimore, Ma	Pages 1 and 2 ament of Health arent of Health arent: If item 27 Is		John V. Wills 7. 20a. Method of Disposition 1 Burial 2 Cremation 3 Rei 4 Donation 5 Other (Specify)	moval from State	72L lace of Dispo emetery, crem edar H	Sition (Name of natory or other plantill Ceme	tery C	Ne 19/15/0	2009 E	Air, Marylo Do. Location - City or 1 Baltimore,	Maryland
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee Rems Aldrid	qe per DVR	40	Name and Address Name a	hie Hig	hway	Balti	,	And 21225 Approximate
8760,	Physician //Medical Examiner	lical Examiner	23a. Part1. Enter the disease, or compilications shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Chronic Due to (or as a consequence to (or as a conseq	Rencuence of): Mellouence of):	11	re.	Mac of res	piratory arres	C	interval Batween Onset and Death Over 14 years Over 10 years
P.O. Box 68	Attending Physicien: The law requires that the death certificate be exit death. •ctor: Afler this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the buria	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of di 9 □ Unknown	death 3	Ectopic pregnand	έy			23d. Date of delin Month	very Day Year
	vrequires that been signed by should be deta	ed by Pr	Part II. Other significant conditions contr	ributing to death but not reso	ulting in the u	nderlying cause gi	ven in Part I.			cco use contribute to	the cause of death?
Vital Records,	sicien: The law requ s certificate has been lirector, page 2 should	Completed						-	24a. Was an autopsy performe 1 ☐ Yes 2	prior to c	opsy findings available ompletion of cause of 2 ☐ No
	Physicien this certifii al director,	To Be	I Tes 21 No	spital:		I 3 DOA	her: 4 Nursi	ng Home	eck only one) 5 □ Residend		7700.100
Division of	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specify	28b. Time of Injury ome, farm, str]Yes 2 ☐ No	28f. L		rinjury occurred et and Number or Rui State)	ral Route Number,
	te Hospite 24 hours te Funerel iletely filled	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my knoer: On the basis of examina and manner stated.	wledge, death tion and/or in	occurred at the treestigation, in my	ime, date and p opinion, death	place, and o	fue to the cau the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of centilier 30. Name and address of person who com-	Vallana	23a) (Type		se number	389		d. Date signed (Month	Day, Year) RIL 2009 TO 47 STOUMD
	Sta	te	PERFECTO C 31. Date filed (Month, Day, Year)	VALARAD 32: Registrar's Signa	HD.	17/61	FARFOR	LD RO	10 Su	105 FALL	STOUMP
	Regist	ar	SEP 2.8 2009	Denter B.	Dar	100					

DHMH 17 Rev 1/2001

Wesley Wood

			State Registrar	Cer	rtificate of L	Death	A	leg. No.	
	Physicia		1. Decedent's Name (First, Middle, Last) WESLEY EARL WOOD JR				2. Date of Deat Septemb	er ^{Da} Ž2, <i>Ž</i> 00	3. Time of Death 9 4:20AМ м
100	Medic Examir		4a. Facility Name (if not institution, give street and number Stella Maris Hospice	r)	4b. City, Town, or Timonium	r Location of Death		4c. County of Dea Baltimor	ith
	Funeral Director		216-20-0228 1XXM 2□F	Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Dec 25 ^a y,	1923 MAY	rthplace (State or Foreign YTand
	d w	_	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	cation				10d Inolds City Limits
	e Marylan r 28a-f sh notified a	Director	Maryland Baltimore	Baltimor	е				10d. Inside City Limits 1 ☐ Yes 2XX No
	n with the is 23a or	Funeral I	10e. Street and Number 216 Dunkirk Road		10f. Zip Code 21212			10g. Citizen of What C	ountry?
920	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f show ter than Medical Examiner must be notified at	β	11. Marital Status 1 Never Married 3 Widowed 4 Divorced 12. Was Decede Agreed Force 11. Marital 12. Was Decede Agreed Force 11. Myes 2 If Yes, Give Year or Date:	□ N9MMII	Was Decedent of H If Yes, specify Cuba 1 □ Yes XX No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	
2-0	hour hatu dical	slet	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	oation during most of work	ina	16b. Kind of Business	Industry
21215-0036	within 72 giene. er than ' the Me	Completed	Elementary/Seconday (0-12) College (1-4-4	or 5+) life. De	sonnel Ma		ng	Manufac	turing
Maryland	팔충동	To Be	17. Father's Name (First, Middle, Last) Wesley Earl Wood Sr			18. Mother's Nam	e (First, Middle, N _ouise H	,	
aryl	2 should be fill thand Mental (than Mental 27 is marked (traumatic every)		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rura	al Route Number,	City or Town, State, Z	ip Code)
	이는 하다		Janice Pauline Wood	Wife 216 D	unkirk Ro	oad Baltir	nore, Ma	ryland 212	12
ore	- 5 - 2		20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Removal from St	20b. Place of Dispo cemetery, cren	natory or other place	ce) !		20c. Location - City o	
Ë	Page ment o tant: If iury or		4 ☐ Donation 5 ☐ Other (Specify)	Lorraine	Park Maus	soleum 9/2		Baltimore,	
Baltimore,	permit. Page Department Important: I any injury o	l.,)	21 A nature of Funeral Service/Licensee	nakes 22					ral Home Inc yland 21212
			23a. Part 1. Enter the disease or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do not enter	er the mode of dyin	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between
-	Physician/		Immediate Cause (Final disease or condition	Secondary to					Onset and Death
1	Medical Examiner			as a consequence of):					
		ner	Sequentially list conditions, b. Due to lor.	as a consequence of:					
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.						
	ertificate be executed ding physician and se as the burial-transit	cal E	resulting in death) Last Due to (or	as a consequence of):					
68760	icate l j phys is the	/Medical	d						
89	certif anding use a		IF FEMALE: 23c. If yes, outcome 23c. Was decedent pregnant 23c. If yes, outcome 23c. If yes,	me of pregnancy th 2 D Fetal death 3 D	Tetania prognana	01/		23d. Date of de	elivery
Вох	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physiciar	in the past 12 months? 1	nt at time of death 5	Other (specify)			Month	Day Year
P.O.	at the	/ Ph	Part II. Other significant conditions contributing to deat	th but not resulting in the u	underlying cause giv	ven in Part I.	23e. Did tol	pacco use contribute t	o the cause of death?
S, F	n signe	ed by					1 □ Y	es 2 X No 3 □ I	Probably 4 🗌 Unknown
örc	w requisible strong	Completed					24a. Was a		utopsy findings available completion of cause of
Rec	The law cate has page 2 s	Nom					perfori	ned? death?	s 2 No
_ Eg	ician: The certificate rector, pag	Be (25. Was case referred to medical examiner?			lace of Death (Check			
Š	hysicathis call dire	은	1 ☐ Yes 2 🗶 No Hospital:	patient 2 ER/Outpatier		4 ☐ Nursing Ho		ence 6 X Other (Spe	cify) HOSPICE
0	tel 19	Certificate:	Natural 5 E Felicing	injury 28b. Time of injury	work	y at ⟨? Yes 2 □ No	28d. Describe ho	w injury occurred	
Sio	Atten r deat ctor; y the	rtific	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	Injury - At home, farm, stre		res 2 🗆 NO	28f, Location (St.	reet and Number or Ri	ural Route Number,
Division of Vital Records,	ital or , irs afte al Dire		4 - Horniciae determined building,	etc. (Specify)			City or Town		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of the b	of examination and/or invest	tigation, in my opinio	on, death occurred at	the time, date an	d place, and due to the	cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	the best of thy knowledge, c	29c. License			9d. Date signed (Mon	
	1		> STANGE CRAP		R149	1792		9/22/20	09
			30. Name and address of person who completed cause of	of death (Item 23a) (Type, F	Print)			*	
				DULANEY VAL	LEY RD.	TIMONIUM	, MD 210	193	
	Sta Registra		31. Date filed (Month, Day, Year) SEP 25 2009 32 egi	strar's Signature	alle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

amend #4c Per Phy G896 10/05/09 JH
State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Sepytember 22, **Physician** 2009[°] 7:42 Marcelino Yaquez /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9010 Wood Park Court Harford Baltimore Parkville 8. Date of Birth (Month, Day, Year) April 28,1951 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1. M 2 □ F 148-42-9908 58 Spain Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show MD Baltimore Parkville Director event, the Medical Experiment must be notified 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 9010 Wood Park Court 21234 USA or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Church/Evangelism Pastor 12 is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be f Health and Mental Emigdio Yaquez Honoria de la Calle ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9010 Wood Park Court-Parkville, Maryland 21234 Sharon Yaguez-spose Department of Health Important: If item 27 any injury or other trong once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel and Cremation SVR Belair 20a. Method of Disposition 20c. Location - City or Town, State Date Pages 1 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Sept.25, 2009 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkviile, Maryland 21234 endrae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 4em disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a nonsequence of) ivision of Vital Records, P.O. Box 68760, burial-transit and Physician: The law requires that the death certificate be execu Due to (or as a consequence of): the as IF FEMALE: asn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy φ in the past 12 months? Month Year Day 5 Other (specify) 1 Tyes 2 No 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1 □Yes 2.2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifie (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who comp pleted cause of death (Item 23a) (Type, Print) 050 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 28 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 940 PM **Physician** G therine 10-2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Manor EIKton
If Under 1 Year | If Under 24 Hrs. Hssisted Living araway (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 M 2 XF Months Days 221-34-3339 Yrs. 05-26-1924 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the New Item Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director IKton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U5A POINT 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: White 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Machine Sewing perator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be avia 2 harles LhorDe 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blud. Middletown Alexander Gloucester daughter Baltimore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) United Cremotory Services 9/14/2009 Newark DE 22. Name and Address of Facility Family Funeral Home Strano + Ferrey Family Funeral Home 9/14/2009 Newark, DE 21. Signature of Funeral Service Licenses luma 635 Churchmans Road, Newerk, DE 19702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
UNKNOWN 23a. Part 1. Enter the disease Heart Disease Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Duz to for as a consequence of and burial-trar Due to (or as a consequence of) attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month for 4 Pregnant at time of death 5 Other (specify) 9 TUnknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed?

1 Yes 2 No this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. 24 hours after death. ► Funeral Director: A within 2 To the I

> State Registrar

completely

Medical

29a. Certifier (Check only one)

29b. Signature and tity of certifier

Serchder 5 mis

Sachder MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

igh St Elklin MD 21921.

29d. Date signed (Month, Day, Year)

9.11.2009

			State of Ma 1 - State Registrar	•	epartment o C <i>ertificate d</i>				giene Reg. No. 🤎 (2100
			Negistrar 1. Decedent's Name (First, Middle, Last)			- Dodin		2. Date of Dea		<u> </u>	3. Time of Death
	Physici		Helen Louis	e Ruttre	777			Septemb	Day	Year 2009	1341 P ^M
- Aug	/Medio		4a. Facility Name (If not institution, give street and number)	C Dattic		n, or Location	of Death	осресии	4c. Count		1541 1
	_xaiiiii		Union Hospital		E1kt	on			Ce	cil	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birtho		ar If Under	24 Hrs. Min.	8. Date of Birt (Month, Da	h v. Year)	9. Birth	place (State or Foreign
	Director		237-34-2423 1□ M 2X F 86	5 Yrs	s. Moritis De	lys Flours	IVIIII.	NOV 11,	1922	Nort	h'Carolina
	ind w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location						I0d. Inside City Limits
	shov	ō	,								1 □Yes 2 VINo
	the N	ect	Maryland Cecil 10e. Street and Number	E1kto	10f. Zip Cod	10			10g. Citizen of	What Cou	
*	a or	ä									,
	death with the Maryland ms 23a or 28a-f show	Funeral Director	29 River Mist Drive 11. Marital Status 12. Was Decedent E	ver in U.S.	219		igin? (Spe	ecify Yes or No			tates
(0	fter d r iten	Ξ	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	5	13. Was Decedent If Yes, specify (Rican, etc.)	Bla	ick, White,	
036	urs a al", o	þ	3 X Widowed 4 □ Divorced If Yes, Give X Year or Dates:		1 □ Yes 2 💢	No Specify:	;		Speci	^{fy:} Wh:	íte
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. D	ecedent's Usual Oc Give kind of work do ife. DO NOT use re	ccupation	t of worki	na	16b. Kind of E	Business/In	dustry
2	thin 7	g	Elementary/Secondary (0-12) College (1-4or 5+	·)			n or works	ng			
7	ed w lygiei ner th	ខ	8	(Custodian			/=/			Education
ano	be fil ntal H sd ott ever	Be	17. Father's Name (First, Middle, Last)						Maiden Surna	me)	
Š	d Me narke	은	Walter A. Hyatt 19a. Informant's Name/Relationship (Type. Print)	100.0	4 11 4 11 (0)			ones	01 7		. 0
N S	d 2 sl th an 7 is r traur				Mailing Address (St						o Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Widtel Evan in extural be notified at Once.		Sherry Buttrey/Daughter-in-	20h Place of Di	River Mi	f		ate ate	20c. Location	921 - City or To	own, State
<u>ē</u>	ages ent of t: If it		1 🖁 Burial 2 ☐ Cremation 3 ☐ Removal from State	Gilpin	crematory or other Manor 11 Park	place)	Septe	ember		-	
₽	artme ortan injur		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Memòria	11 Park	dress of Facili	22, 2		EIK	ton,	MD
Ba	Dep Imp any		K. H. DE		Programme and Addition Hicks Ho	me for	Fune	erals,	P.A. lkton	MD 2	1921
			23a. Part 1. Enter the disease, or complications that caused t	he death. Do not							Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line immediate Cause (Final		. e.a. G.	lat an					Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a	consequence of):		ione					- 24 hours
	Examiner		1 2 f+	((ded	Nyeven	Ouic					2 d 571
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	eunsequence of).							
de	ficate be executed g physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				_				
68760,	e exe	Ĕ.	resulting in death) Last Due to (or as a	consequence of):	•						
876	ate b	edical	d								
9	ertific ling p	Mec	IF FEMALE:							. 1	
Вох	attend or us	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 ☐ Live birth 2	☐ Fetal death	3 ☐ Ectopic pregr					ate of deliv Ionth	rery Day Year
P.0.	the a	/sic	1 ☐ Yes 2 No 4 ☐ Pregnant at 9 ☐ Unknown 9 ☐ Unknown	ime of death	5 Other (specif	v)					,
σ.	w requires that the death certif i been signed by the attending should be detached for use as		Part II. Other significant conditions contributing to death but	not resulting in th	ne underlying cause	given in Part I	l.	23e. Did to	obacco use cor	ntribute to t	he cause of death?
g	uires sign d be	d by	Sepsis and seption	c 5400	K			1 🗆 1	res 2 No	3□ Pro	bably 4 ☐ Unknown
00	v req beer shou	Completed	Acupe reyal for	-Care				24a. Was	21h	Mara nut	anny findings available
Be	ne lav e has ge 2	m	7) 65 16 1649 19	11070				autop	osy rmed?	prior to co death?	opsy findings available empletion of cause of
a	ificate ificate or, pa	ပို	25. Was case referred to medical					1 ☐ Yes	2 No	1 🗆 Yes	2 🗆 No
Ē	sicia s cert lirecto	m	examiner?	nt 2 ER/Outpa	ationt 2 DOA	011		(Check only o	<i>ine)</i> dence 6 □ Ot	h (O	
Division of Vital Records,	y Phy er this eral d	Ĕ	27. Manner of Death 28a. Date of Injury	y 28b. Tim		Injury at Work?			now injury occu		<u>(17)</u>
<u>ö</u> .	nding ath. r; Aft e fun	aţio	1 (Month, Day, 2 ☐ Accident investigation (Month, Day,	Year) Inju		Work? 1 □ Yes 2 □	No				
<u>×</u>	Atte	ij	3 Suicide 6 Could not be	y - At home, farm	, street, factory, off	ce		28f. Location (S	Street and Num	ber or Rur	al Route Number,
	tal or 's afte al Dir ed in	Certification: To	4 ☐ Homicide determined building, etc.	(Specify)				City or Tov	WI, State)		
	lospi hour uner		29a. Certifier (Check only) Certifying Physician: To the best of 2 Medical Examiner: On the basis of	my knowledge, o	death occurred at the	ne time, date a	nd place,	and due to the	cause(s) and n	nanner as	stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	one) and manner stat	ed.			000011				
	Viti	2	29b. Signature and title of certifier			ense number	O/A		29d. Date sign		
			30. Name and address of person who completed cause of de Alfred A Pirro Mb		100	0551	70		syte	in ver	17 2009
	H		30. Name and address of person who completed cause of de	ath (Item 23a) (Ty	rpe, Print)	11 10	6 17		6- 6	142	. Will
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 18 200 Deptember Mary Wells Bollino /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington

9. Birthplace (State or Foreign Country) Boonsboro If Under 24 Hrs. Fahrney-Kedy Memorial Home
5. Social Security Number | 6. Sex | 7. Ag 8. Date of Birth (Month, Day, (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 ■ F June 15 88 1921 Mary land **Director** 213-44-1642 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ortant; If Item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Allegany MD Frostburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21532 U.S.A. 16 Frost Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural" any injury or other trainer. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. Specify: 2 3. Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marcella Wells Clyde Wells ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Sellers daughter Appian Way Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09-21-09 <u>Michael Cem.</u> Frostburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, P.A.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximated Cause (Final) Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Inu disease or condition resulting in death) a /Medical Due to (or as a consequence of): **Examiner** 12hcimer Sequentially list conditions, if any, leading to minisorate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. nding physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 □ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Narsing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | No. 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month,

ARID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MJ

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32. Registrar's S

29c. License number

0060396

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept . Day Year **Physician** PATRICIA A. BURLESON 1:45 PM 13 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY POTOMAC CARE MAMOR If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Aug. 19, 1933 West virginia 7. Age (In yrs. last birthday) 76 9. Birthplace (State or Foreign **Funeral** Months Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notifled at 1 ☐ Yes 2 No Director Maryland Montgomery Germantown 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 2 should be filed within 72 hours after death with nand Mental Hygiene.

is marked other than "natural", or items 23a or " 17632 Burdette Lane 20874 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 □Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unit Secretary Holy Cross Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vaughn Ashton Lilly Helen May Greene P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun Martha A. Chopas/Daughter 17409 Flagstone Drive, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Sept. 2009 17 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
_500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THRIVE FAILYRE Physician /Medical Due to (or as a consequence of): METASTATIC LYNG CANCER Examiner ADVANCED Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-tran Due to (or as a consequence of): physician a Box 68760 Physician/Medical use as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed? 1□ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director; After t 28c. Injury at Work? After Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

DHMH 17 Rev 1/2001

State

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Pinky Singh, MD 6502 Kenilworth Avenue, Greenbelt, MD 20737 3 Registrar's Signature

MD

29c. License number

00057458

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

/Medical
Examiner

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Examinant by malled at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

• the Funeral Director: After this certificate has been signed by the attending physician and property filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

1	For State Registrar			Cer	tificate of l	Death		Reg. No.	2009	3 1 0 0 8			
1	. Decedent's Name (First, Middle, Las	et)					2. Date of De	ath Day	Year	3. Time of Death			
	Ereselle Helen	Brooke					09	05	2009	3:54p M			
4	a. Facility Name (If not institution, give				4b. City, Town, or	Location of Death	1	4c. C	ounty of Death				
Æ	Washington Adven	tist Hospi	ita1		Takoma				ontgome	•			
	. Social Security Number 6. Se	ex 7. Age □ M 2 ☑ F		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th a <i>y, Year)</i>		place (State or Foreign intry)			
	0/5-22-5034	LIM ZKLF	85	Yrs.			5/27/1	924	Virg	rginia			
- H	Jsual Residence of Decedent 0a. State 10b. County	_	10c. City	, Town or Lo	cation					10d. Inside City Limits			
_	DC			shing						1 ▼Yes 2 No			
2	0e. Street and Number				10f. Zip Code			intry?					
5 '	4806 Eastern Aven	ue. NE			20017		United States						
1 4	1. Marital Status	12. Was Decedent I	Ever in U.S	S. 13. V	Nas Decedent of H	ispanic Origin? (Sr	pecify Yes or No- 14. Race - A			merican Indian,			
Funerar Directo	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📆 N			f Yes, specify Cuba	n, Mexican, Puerto	o Rican, etc.)		Black, White, etc. Specify: African				
<u>~</u>	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	I□Yes 2₺No	Specify:		erican					
Completed	15. Decedent's Ed	ucation		16a. Deced	dent's Usual Occup	ation		16b. Kind	of Business/Ir				
를 -	(Specify only highest grade Elementary/Secondary (0-12)		+)	life. L	kind of work done o	luring most of worl ()	King						
ξ L	Ziomoniary, obtoniary (o 12)	College (1-4or 5		Resea	rch Anal	yst		Libra	ary of	Congress			
ם ב	7. Father's Name (First, Middle, Last)				18. Mother's Name (Firs				urname)				
	David Mercer					Martha							
Ţ	19a. Informant's Name/Relationship (7	Type. Print)		19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numb	er, City or	Town, State, Z	p Code)			
	Cheryl Brooke/Da	ughter		415 A	shaway La	ane, Uppe	r Marlb	oro,	MD 20	774			
2	20a. Method of Disposition		20b. Pl	lace of Dispo	sition (Name of natory or other place	e)	Date	20c. Loc	ation - City or T	own, State			
	1 In Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify				nal Cemet	i	6/2009	Laur	el, MD				
1	21. Storoutire of Funeral Service Licen	See NINB		22	2. Name and Addres	ss of Facility Mc	Guire Fu	unera	1 Servi				
+	23a. Part 1. Enter the disease, or comp	NUCCO	the death						iigotii,	Approximate			
	shock, or heart failure. List only of	one cause on each lir	ie.			-				Interval Between Onset and Death			
- 1	Immediate Cause (Final disease or condition resulting in death)	a. Arterio	2014	vote	Cardio	Vascular	D11-00	212		years			
	1	Due to (or as	a consequ	ience of):									
5 3	Sequentially list conditions,	b. Due to (or as	n according	constant									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 (0) 43	a oonsequ	ichico cij.									
Ya t	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of);									
vieulcai Examiniei				, .									
2		d											
	IF FEMALE:	23c. If yes, outcome	of pregna	ncy				200	3d. Date of deli	verv			
riiysiciaii/i	in the past 12 months?	1 Live birth 4 Pregnant a	2 🗆 Fetal	death 3	Ectopic pregnanc Other (specify)	у			Month	Day Year			
2	1 □ Yes 2 ■ No 9 □ Unknown	9 Unknown	01 01	JL									
	Part II. Other significant conditions co	ontributing to death be	ut not resu	ılting in the u	nderlying caus <i>e</i> giv	en in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?			
2	CandionyonaTh	y Dec	04:	tus U	Icers		1 🗆	Yes 2□	No 3□ Pro	obably 4 Unknown			
ן פוני	DALL YOU E	ilune Va				Puce	24a. Was	an	24h Ware au	topsy findings available			
completed by							auto		prior to c death?	completion of cause of			
	End Store Rena	DISEAC	₹.	13165	etes Mul		1 □ Yes	2 No	1 ☐ Yes	2 🗆 No			
ם	25. Was case referred to medical examiner?	Hospital:			oth Oth	26. Place of Dea							
-	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a Date of Inju	irv	ER/Outpatier 28b. Time of	IL 3 LI DOA	4 LI Nursing H	lome 5 Resi			ify)			
<u> </u>	1 Natural 5 ☐ Pending	(Month, Da	y, Year)	Injury	Worl	yaı <br Yes 2∐No	Zou. Destribe	, iow injury	COCUITEU				
2	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		irv - At ho	me farm etr	eet, factory, office	109 5 E 140	28f. Location	Street and	Number or Pu	ral Route Number,			
	4 ☐ Homicide determined	building, et	c. (Specify	<i>()</i>	cot, ractory, onice		City or To	wn, State)	realined of Na	a. House Halliber			
2	29a. Certifier 1 ☑ Certifying Ph	ysician: To the best	of my know	wledge, deat	h occurred at the ti	me, date and place	e, and due to the	e cause(s)	and manner as	stated.			
		niner: On the basis of and manner sta	f examinat										
	29b. Signature and title of certifier				29c. Licens	e number		29d. Date	signed (Month	ı, Day, Year)			
Phullindeviro and Do1852									September 6, 2009				
	Phullmellire and DESS & JEPACHTER,												

State Registrar Pari A. Delv 31. Date filed (Month, Day, Year)

15 2009

DEVORE MD 4203 Queensbury Rel Hz attsuille MD 20781

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 10:12a M **Physician** 2009 September 12 Edward Weeks Brand /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring 2901 S. Leisure World Blvd., #234 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours Min 1 X M 2 ☐ F Yrs. October 25, 1928 District of Columbia 80 Director 578-34-1154 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Exar, item instituted at 1 ☐ Yes 2 X No Director Silver Spring Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 U.S.A. 2901 S. Leisure World Blvd., #234 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify: Specify 2 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) halth and Mental Hygiene. Federal Government Systems Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental Catherine Weeks Albert W. Brand ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2901 S. Leisure World Blvd., #234, Silver Spring, Maryland 20906 Department of Health Important: If Item 27 any injury or other to once. Alma Brand - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 09/17/2009 Silver Spring, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 20 42003 coronar /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncernying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Physician/Medical the, attending pl IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? icate has t , page 2 s performed certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Division of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐ Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manper of Death After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A letely filled in by the fu investigation 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier To the Host within 24 hor To the Fune completely fi (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00051841

State Registrar

Baltimore,

PRUSPERITY DR. SILVER SPRIND MD 2090

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GLENN

5

31. Date filed (Month, Day, Year)

M-0

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 12, 2009 **Physician** JOSEPH LEROY BURTON, SR. 1843 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES RESIDENCE. 2155 BRIARWOOD DRIVE WALDORF If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** NOVEMBER 3, 1936 Months Hours Min. Days 72 WASHINGTON, D.C. 220-32-5255 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Mydical Examinar must be notified at 1 □ Yes 2 🙀 No Director MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2155 BRIARWOOD DRIVE 20601 UNITED STATES Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Mayes 2 □ No 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No If Yes, Give Specify: à BLACK 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Telementary/Secondary (0-12) College (1-4or 5+) EXPLOSIVES OPERATOR FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CATHERINE LULA SMITH BURTON WALTER BURTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2: ment of Health a tant: If Item 27 is 20601 BRENDA M. BURTON / WIFE 2155 BRIARWOOD DRIVE, WALDORF, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or or 1 La Burial 2 ☐ Cremation 3 ☐ Removal from State ST. JOSEPH'S CHURCH CEM. SEPTEMBER 18, 2009 POMFRET, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funcial Service Licensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed as the burial-transi and Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the attending pathed for use as i IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ned by the a ☐Yes 2☐No 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this မ funeral (28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

31. Date filed (Month, Day, Year) SEP 1 4 2009

29b. Signature and title of certifier

32. Régistrar's Signature

no completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) 11, 2009 **Physician** September 8:29 MARION MAGDALENE BRAUER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Golden Living Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 14, Illinois 1 □ M 2 😾 F 335-18-5204 86 Nov. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County r than "natural", or items 23a or 28a-f show the Medical Experience roust be notified at 1 ☐Yes 2 ☐ No Director Frederick Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 U.S.A. 1945 Fieldstone Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 XNo Specify If Yes, Give Year or Dates: Specify: ģ White 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens important: if item 27 is marked other that any injury or other traumatic event, the any in. Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Conen Frank Brodfuehrer ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1945 Fieldstone Lane, Frederick, Maryland 21702 Greg Brauer / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 9/15/09 Frederick, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License ROBERT E. DAILEY & SON FUNERAL HOMES, nle 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available 2 Be Certification: To 2

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Hygiene.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

					performed?	death? 1 Yes 2 No					
5. Was case refer	red to medical			26. Place of Death	(Check only one)						
examiner? 1 ☐ Yes 2 🔄	No I	Hospital: 1 ☐ Inpatient 2 ☐	1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
7. Manner of Deal 1 Natural 2 Accident	th 5 ☐ Pending investigation	(Month, Day, Year)	28b. Time of Injury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred					
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		me, farm, street, factory,	office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,					
9a. Certifier (Check only one)	1 CertifyIng Ph	nysician: To the best of my knowniner: On the basis of examina and manner stated.	wledge, death occurred a tion and/or investigation,	t the time, date and place, n my opinion, death occurr	and due to the cause(s) a red at the time, date and p	and manner as stated. place, and due to the cause(s)					
Oh Signatura and	Little of certifier		290	License number	29d, Date	signed (Month, Day, Year)					

House Ave, Frederich, MD 21701

State Registrar

Medical 2

31. Date filed (Month, Day, Year)

14

30. Name and address of pers

801 212 MD 32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 2340 PM 2009 Bannon 04 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SAUSBUN 110000100 TENIN SULP MEDICAL TREGIONAL If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 1 - 22 - 1923Maryland Director 213-26-9671 86 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the "refer traumatic eve 1 ☐ Yes 2X No Director Salisbury MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 1400 N. Arbutus Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 1940— If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc within 72 hours after 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No <u>م</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. s marked other than Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement Detective 10 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any Injury or other traumatic event Unknown 17. Father's Name (First, Middle, Last) Be Helen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1124 Hillcrest Avenue, Salisbury, Maryland 21804 Robert Antoline - Stepson Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9-14-2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 22. Name and Address of Facility Bounds Funeral Home Signature of Funeral Service Licensee 705 E. Main Street, Salisbury, Maryland 21804 Se 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner source liany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine as the burial-transi ongres five that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760, physician certificate be Dabetee Physician/Medical the attending IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy jo Month 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 🗌 Yes 2 □ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has I performed 2 No 1 ☐ Yes Physiclan: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number 9/10/09 mod. 120067738 VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) arrall St. ma 21801 Registrar's Signatur Year) State Registrar

09-07222 Lisa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Lisa V. Banks		- For State	St	ate o	f Maryl	and / D	epart	ment of ficate of	Health	and	Menta	al Hygie		g. No.	2.0	19	3101
Physician	/ 1	egistrar I. Decedent's Name										l Mc	ate of Death	Day	Year		e of Death 31 hrs
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Funeral Director	- 1	5. Social Security N 577–94–327		6. Sex	л 2 ^X F	7. Age (In	yrs. last	birthday) Yrs.	If Under Months		If Under: Hours		Date of Birt 2/02/19		DD/YYYY) 9. Bi Forei C	rthplace ign Was ountry)	(State or hington DC
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to ow an		10a. State MD	10b. County Anne A	hund	el	100		apolis	OII								Yes 2 No
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	==	11. Marital Status 1 X Never Marrie		larried	Armed I	ecedent Eve Forces?	r in U.S. No	If Y		Cuban,	Mexican, F	n? (Specify Puerto Ricar			14. Race - Ame White, etc. Specify:	erican Ind	dian, Black,
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	e Be	Kenneth '			ne Print \			19b. Mailine	n Address	(Street		Banks Der or Rural	Route Nur	mber, C	ity or Town, Sta	te, Zip C	Code)
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Baltimore, Nermit. Pages I and Department of Healt Important: If item Imjury or other transingury or other transituations or other tran			Crematio		Removal	from State	cre	ace of Disposematory or ot	her place)			Da 09/25/2		1	Location - City		State
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× 4 5 5	sician/Me	IF FEMALE: 23b. Was decedent past 12 month	s?		1 Live	s, outcome e birth egnant at tim		2 F	etal death other (Spec	3 [ify)	Ectopic	pregnancy		20	3d. Date of deliv Month	Day	Year
the deat	훕	Part II. Other sign				to death b	ut not res	sulting in the	underlying	cause g	iven in Pa	rt I.	23e. Did	tobacco	use contribute	to the c	ause of death?
of Vital Records, P.O. ing Physician: The law requires that th After this certificate has been signed by uneral director, page 2 should be detach	ক্র					,							1 Y6	es 2	✓ No 3 F	robably	4 Unknown
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Division of Vital Records, To the Hospital or Attending Physician: The law requin within 24 hours after death To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should t	ertification:	2 Accident 3 Suicide 4 Homicide	6 Co	estigation uld not termined	28e. P	-	y - At ho	me, farm, str	eet, factory	office b	uilding, et	c. 28	f. Location or Town,		and Number or	Rural R	oute Number, City
Di To the Hospital within 24 hours a To the Funeral	Medical C	29a. Certifier (Check only one)	Certifying Medical Ex	Physici	an: To the I	sis of examin	nowledg	e, death occi id/or investig	urred at the ation, in my	time, da opinion	ate and pla	ace, and due	e to the ca e time, dat	use(s) a te and p	and manner as solace, and due to	stated. o the car	use(s)
F.3 F.3	₩	29b. Signature an	d title of certi	fier)				290		e number			- 1	. Date signed		
		30. Name and add	dress of pers	on who d	completed of	ause of dea	ath (Item			O.C.				Se	eptember 16	5, 2009)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Crabtree Juanita 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND MEMORIA If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 5, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 2□xF Hours Min 215-26-6681 81 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show traumatic event, the Medical Exacting must be notified at MD Oldtown Allegany 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 may injury or other traumatic event, the Medical Evan's at must be an expres. 21555 18511 Oldtown Road, SE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. þ 3 Nidowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Labortatory Technician Celanese Corp 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Homer Buckley Myrtle A. Twigg Buckley ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 3 Oldtown MD 21555 19a. Informant's Name/Relationship (Type. Print)
Shirley Kimble niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Davis Memorial Cemetery 9/21/2009 Cumberland MD 4 ☐ Donation 5 ☐ Øther (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licens-108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, ir comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure and strong or each second or in line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or cond in resulting in deat **Physician** NEUMO /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed aftending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d, Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐No by the a 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 AR THRIT 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy 1 ☐ Yes 2 ☑ No 2 INO 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩6 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed, (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sta

State Registrar 31. Date filed (Month, Day, Year) SEP 28 2009

12. D. 1221-E National Highway LAVALE, ND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** onne lle Margare ma /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner fleam umber Fairview 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Months Days Hours 220-26-937 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I've Medical Evarines must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2 No Md Funeral Director umberland Allegan 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21203 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Fradiska Gillard Hubert L. Gillard ဂ္ 19a. Informant's Name/Relationship (Type. Print)
Thomas Connelley Mailing Address (Street and Number or Rural Route Number, City or Town, State, 612 Fairview Avenue Cumberland Zip Code) MD 21502 husband 20a. Method of Disposition

1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place)
SS Peter and Paul Cemetery Date 20c. Location - City or Town, State 9/21/2009 Cumberland MD 21. Signature of Funeral Savice Livenses 22. Name as Carbelle Fulleral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Efter the dis se, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of peart fail ins. List only of e cause on each line. Approximate Interval Between Onset and Death Immediate as se (Final disease or dition resulting in sath) **Physician** montho ovan an /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if an leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 ☐ Yes 2 No ours after death. eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) SEP 28 2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** RAH De DIEMBER /Medical ounty of Death 4a. Facility Name (If not institution give street and number 4b. City, Town, or Location of Death **Examiner** If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-6-1963 5. Social Security Number 7. Age (In yrs. last birthday, If Under Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 3 1 □ F MD. 212-88-3182 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director MD. PRINCE GEORGES CLINTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9106 PINEVIEW LANE 20735 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE SECRETARY LAW FIRM 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN FRANKLIN EDELEN, SR. MARY ESTELLE WHEELER ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARY E. EDELEN-MOTHER 3406 PEARL DR. APT.201 SUITLAND, MD. 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State HERITAGE MEM.GARDENS 9-22-09 WALDORF, MD. M00479 21. Signature of Funeral Service Licenses 23 Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onget and Death Immediate Cause (Final disease or condition resulting in death) RR HOSIS **Physician** /Medical Due to (or as a consequence of): Examiner CORT Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed /sician and Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 ☐ certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 251 No. 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 21No 1 ☐ Yes 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 N 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day,

32. Registrar's Year! SEP 28 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY Month 2009 **Physician** WALTER CHAVIS 10:30PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MANOR CARE OF POTOMAC MONTGOMERY POTOMAC 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9/25/1941 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 XM 2 ☐ F ROXOBORO, NC 67 243-68-7980 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1√PYes 2□No Director DC WASHINGTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1221 M 20005 ST., NW UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
unt: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 🔏 No Specify: BLACK 2 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (College (1-4or 5+) LABORER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GEORGE CHAVIS MARY O'BRAINT ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trauonce. 459 BOX#3316409130 AUDREY L. FERGUSON/DAUGHTER 317 MAINTENCE CO CMR 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MT. OLIVET CEM. 5/13/09 WASHINGTON, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee CAPITOL MORTUARY 1425 MARYLAND AVE. NE WASH. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failule. Immediate Cause (Final Physician CANCER LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and the detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed **2X**□No certificate 1 ☐ Yes 2 📉 No 1 ☐ Yes after death.

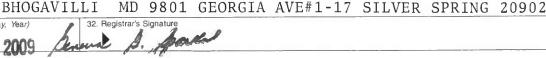
Director: After this certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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SUNITHA 31. Date filed (Month, Day, Year, State Registrar

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number D0054566

29d. Date signed (Month, Day, Year)

5/6/09

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 18, **Physician** DOROTHY MAE CRESAP 2009 9:05 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON WILLIAMSPORT WILLIAMSPORT NURSING HOME If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Pay, Year) 3/21/1915 **Funeral** 94 Days PENNSY LVANIA 232-62-9689 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show WV BERKELEY MARTINSBURG 1 TYes 2 TNo event, the Medical Examinar must be notified Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 filed within 72 hours after death with 25404 USA 238 RICHARD STREET 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE þ 3 ₩ Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. OWN HOME permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other that any lojury or other traumatic event, Inv. 100. HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
WILLIAM T. BROWN Be ELENORA M. WOLFORD ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 238 RICHARD STREET, MARTINSBURG, WV 25404 JUNE CUTLIP/CAREGIVER Baltimore, 20b. Place of Disposition (Name of PLEASANT VIEW 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ⅓ Burial 2 ☐ Cremation 3 ☐ Removal from State SEPT. 22. MARTINSBURG. UV 4 ☐ Donation 5 ☐ Other (Specify) MEMORY GARDENS 2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, haeles M. Deaun 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASPIRATION WEEKS NEWMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SPHAGLA MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed CERETSRAL INFARCT physician and is the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗹 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) the 9 Unknown ģ The law requires that signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ₫ 2∑No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 X No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 XNatural 5 Pending investigation in 24 hours and the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe Hember ZI, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOWE N. ARTICAN ST. (ed E 31. Date filed (Month, Day, 32. Registrar's Signat State Registrar SEP 28 20

DHMH 17 Rev 1/2001

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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	t 23c.	1 Live bir	ome of pregn rth 2 Feta ant at time of wn	al déath 3[☐ Ectopic pregna ☐ Other (specify					Date of delive Month	ery Day Year
that ned b deta	y P	Part II. Other significant co	nditions contrib	outing to dea	th but not res	sulting in the u	nderlying cause	given in P	art I.	23e. Did to	bacco use co	ontribute to t	he cause of death?
quires an sign	od by	Chron	c OL	25/10	-cti'u	e Pul	mercan	n.s	ease	1 □ Y	es 2 No	3 ☐ Prol	bably 4 ☐ Unknown
aw requires been si	Completed						\circ			24a. Was a		b. Were auto	ppsy findings available
The la	mo.									autops perfor 1 □ Yes	med? 2 No	death?	mpletion of cause of 2 No
ian: ertifica	BeC	25. Was case referred to me	dical					26. F	Place of Deat	h (Check only or		1 🗆 103	2 🗆 140
hysic his ce		examiner? 1 ☐ Yes 2 ☑ No	Hosp	IXIII] ER/Outpatie	nt 3 □ DOA	Other: 4 E	☐ Nursing Ho	ome 5 🗆 Resid	ence 6 🗆 0	Other (Specia	fy)
ing P	on:	27. Manner of Death Natural 5 □ Pe		28a. Date of Month)	Injury , <i>Day, Year)</i>	28b. Time o Injury		njury at Vork?		28d. Describe h	ow injury occ	curred	
teath.	cati	2 ☐ Accident in	estigation					□Yes :	-				
tal or Atrs after of all Directed in by	Certification: To		termined	28e. Place o building	f Injury - At h g, etc. <i>(Sp</i> ec	iome, farm, sti ify)	reet, factory, office	ce		28f. Location (S City or Town		mber or Rur	al Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical				sis of examin					, and due to the or red at the time, o			
Vithin Vithin Comp	Me	29b. Signature and title of ce	rtifier				29c. Lic	ense numb	ber	2	9d. Date sig	ned (Month,	Day, Year)
		MIGH	ave V	CO			MI	516	10		9/10	0/09	
		30. Name and address of pe	rson who comp	leted cause	of death (Ite	m 23a) (Type,	Dulud	N	10	2-17	02		
Stat	е		(ear)	32. Re	gistrar's Sign	ature	b	1		/			
Registra	ır	SEP 28 2	009 2	neur	B. ,	pak							
HMH 17 Rev 1/20	01	O La Table	- /		-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Ye ar} 2009 September 14, 5:00 aM Timothy Connors, Sr. 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Howard Glenwood 14010 Ardara Court 8. Date of Birth (Month, Day, Nov. 26, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday , 194<u>1</u> Hours Months Days Washington, DC 1 M 2 □ F 67 578-54-6273 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Glenwood Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21738 USA 14010 Ardara Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 X Married White 1 □Yes XXNo Specify: Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DC Government Firefighter 18. Mother's Name (First, Middle, Maiden Surname)

Rita Walsh

20c. Location - City or Town, State

Silver Spring, Maryland

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Sept. 2009

14010 Ardara Court, Glenwood, MD 21738

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

ò

Completed

Be

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

John Leo Connors

19a. Informant's Name/Relationship (Type. Print)

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

Anne M. Connors/Wife

4 ☐ Donation 5 ☐ Other (Specify)

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mydical Evan, inst., unit be redifficed at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit been signed by the should be detached funeral director, page 2: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

Be Completed by Physician/Medical Examiner

Medical Certification: To

31. Date filed (Morith, Day, Year)

SEP 15 2009

21. Signature of Egneral Service Licens		22. Name and Address of Facility Francis J. Collin 500 University Bl	s Funeral Home Inc vd. W., Silver Spr	ing, MD 20901
shock, or heart failure. List only of Immediate Cause (Final	lications that caused the death. Do not ne cause on each line. Lung Cancer	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death 2 years
disease or condition resulting in death)	Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a consequence of):			
resulting in death) Last	Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of d Month	elivery Day Year
Part II. Other significant conditions co	ontributing to death but not resulting in th	ne underlying cause given in Part I.	23e. Did tobacco use contribute 1 ☐ Yes 2 🎦 No 3 ☐	to the cause of death? Probably 4 ☐ Unknown
		·	autopsy prior to performed? death'	autopsy findings available o completion of cause of ? es 2 □ No
25. Was case referred to medical		26. Place of Dea	ath (Check only one)	
examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	atient 3 DOA Other: 4 Nursing F	Home 5 X Residence 6 ☐ Other (Si	ecify)
27. Manner of Death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	28a. Date of Injury 28b. Tim (Month, Day, Year) Inju		28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
29a, Certifier 1 △ Certifying Ph (Check only 2 ☐ Medical Exan	ysician: To the best of my knowledge, on the basis of examination and/and manner stated.	death occurred at the time, date and plac or investigation, in my opinion, death occ	be, and due to the cause(s) and manner urred at the time, date and place, and d	as stated. ue to the cause(s)
29b. Signature and title of certifier	w.)	29c. License number 3 4413 9	29d. Date signed (Mo	nth, Day, Year)
30. Name and address of person who clement Knight,	completed cause of death (Item 23a) (Ty MD 10710 Chart	rpe, Print) ter Drive, Columbia	n, MD 21044	

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

State

Registrar

2. Registrar's Signature

oseph A. Cleme		State of Maryland / Department of I		ygierie Rea. N	201	19 3102
Physicia		edistrar . Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
Medical Examin	er	Joseph A. Clements		Month Da September 1		1057 hrs
	ŕ	at I don't I traine (it that the traine it give a traine it is	. City, Town, or Location of Death Charlotte Hall		4c. County of Death Charles	
Funeral		is Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	. 8. Date of Birth (M	IM/DD/YYYY) 9. Birt	hplace (State or
Director	1	215-38-3056 1X M 2 F 77 Yrs.	Months Days Hours Min.	May 9,	1932 Foreig	Maryland
>	_	Usual Residence of Decedent Oa. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
J cow any		Oa. State 10b. County 10c. City, Town or Location Charles Charlott				1 Yes 2X No
Maryland 28a-f show d at once,	Director	0e. Street and Number	10f. Zip Code	10g. (Citizen of What Cour	ntry?
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.		11660 St. Mary's Church Road	20622		USA	
th with	ō١	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was 14. Never Married 2 Married Armed Forces?	Decedent of Hispanic Drigin? (Sps., specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
er dear	ᇍ	1 X Yes 2 No	Yes 2 No specify:		Specify:	White
ours afi	함	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	s Usual Occupation (Give kind of st of working life. DO NOT use ret		b. Kind of Business/I	ndustry
5-0036 The within 72 hours after of the within 72 hours after of other than "natural", of the Medical Examiner in the Medical	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	rmer	ileo)	Farming	
-003 d within giene. ther th	<u>E</u>	12 17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
215 be filed ntal Hy rked o	8	William Noble Clements.Sr.	Christ	ine Mudd		
imore, MD 21215-0036 Pages I and 2 should be filed within 7 ment of Health and Mental Hygiene. Itant: If item 27 is marked other than or other traumatic event, the Medica	岭	19a. Informant's Name/Relationship (Type, Print) Kelly Barnes/Daughter 19b. Mailing P.O. B	Address (Street and Number or Sox 2402 La Plat	Rural Route Number	r, City or Town, State 546	e, Zip Code)
2 20 2	H	20a. Method of Disposition 20b. Place of Disposit	ion (Name of cemetery,		0c. Location - City or	Town, State
Baltimore, permit. Pages I a Department of He Important: If ite		1 X Burial 2 Cremation 3 Removal from State St. Mary	s Newport 9/	24/2009	Charlotte	Hall,MD
Baltimo permit. Page: Department o Important:	ŀ	1100545	ame and Address of Facility	EDAT HOME	. D. 4 . 00	(16
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	CHART-ECHOLS FUN			Approximate Interval
Physician /Medical	1	failure. List only one cause on each line.		or respiratory an est	SHOCK, OF TEAT	Between Onset and Death
xaminer	1	Immediate Cause (Final disease or condition resulting in death) a Blunt in uries to che Due to (or as a consequence of):	st			
		Sequentially list conditions, b.				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
ed asit	Exar	events resulting in death) Last Due to (or as a consequence of);				
60, ate be executed hysician and e burial - transit		Xunpended Amended 23a,27,28a=f,p	ermE, g896 10/3	0/09 TT		
760, cate be	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	· .
ox 6876 eath certificate attending phy for use as the	ian/	past 12 months?	al death 3Ectopic pregr ner (Specify)	nancy	Month	Day Year
Box 687/ re death certifice the attending p	Physician/Medical	1 Yes 2 No 9 Unknown g Unknown	ler (Opeony)			
that the	by P	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part 1.		acco use contribute to 2 ✓ No 3 Pro	the cause of death?
ords, F w requires s been sign	fed			24a. Was an	24b. Were a	utopsy findings available
COFC law re has be	Completed			autopsy	ed? death?	completion of cause of
tal Rec cian: The l certificate		25. Was case referred to medical	26.Place of Death (Chec	1 Yes 2 k only one)	No 1 🗸	res Z NO
Vital P ysician: his certifi director,	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other Nurs		esidence 6 🗸 Oth	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is allor death. In Invector: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Ir		28d. Describe ho between	winjury occurred SU wheel of	ibject found nis truck
r Attend rer death. irector:	catic	Pending Investigation Fd 9/18/09 Fd 11:2		and tree		Rural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) farm	it, ractory, emos canaling, etc.	Rd or Town, Sta	te)11660 St Totte Hal	Rural Route Number, City Mary Churc 1, MD
Hosp 4 hot Func ely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	red at the time, date and place, ar	nd due to the cause(s) and manner as sta	ated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.				
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (M September 19,	
		30. Name and address of person who completed cause of death (Item 23a)				
BB		Margarita Korell MD. Assistant Medical Examiner 111 P.	enn Street, Baltimore, MC	21201		
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	all			
Regist	rar	SET 2 2 2009 Jeneur B. J.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** \mathbf{p}^{M} 7:02 Julia_ Ann Cooney September 16 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Ridgely
If Under 1 Year | If Under 24 Hrs. 311 Park Avenue
5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🖾 F March 19,1938 South Carolina Director 216-34-1288 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County if than "natural", or items 23a or 28a-f show 1 XYes 2 No Director Ridgely Caroline Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States of America 21660 Funeral 311 Park Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ∐Yes 2**X** No Specify 3 Widowed 4 Divorced Caucasian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Adult Day Care 2 should be filed win and Mental Hygier is marked other the 10 Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Wilbur Gunter Julia Baxley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 311 Park Avenue, Ridgely, Maryland 21660 of Disposition (Name of Date 20c. Location - City or Town, State Husband Paul E. Cooney Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Denton, Maryland Denton Cemetery 4 Donation 5 Dother (Specify) 9/19/09 21. Signature of Funeral Service Land 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final X1-10-1-**Physician** Clar on 2 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sels consequence of) Examiner be executed and burial-trar Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes Corbactiva heard tailure 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation a er dea.h. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours are death. To the Funeral Director A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 1/2001

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State

railrens

30. Name and address puson who completed cause of death (Item 23a) (Type, Print)

fermaneth.

31. Date filed (Month, Day, Year)

SEP 18 2009

716

32. Registrar's Signature

09-07287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Julia E. Cotton 1- For State Certificate of Death Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year September 16, 2009 1630 hrs Julia Elizabeth Cotton **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Peninsula Regional Medical Center Salisbury 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** oreign Min Months Days Hours Country) MD Director 10-1-1963 216-82-9077 2X F 45 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Xyes 2 No MD Somerset Princess Anne Pages 1 and 2 should be filed within 72 hours after death with the Maryfand Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 30476 Pine Knoll Drive 21853 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married Married 2 XNo Yes SpecifyBlack Yes 2 XNo specify: If Yes, Give Yee 3 Widowed 4 X Divorced ⋧ 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Somerset County Elementary/Secondary (0-12) College (1-4 or 5+) nt of Health and Mental Hygiene. ht: If item 27 is marked other than " other traumatic event, the Medical o Baltimore, MD 21215-0036 Health Dept Addiction Counselor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Regina Frances Whittington Be Johnie M. Thomas, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 853 19a. Informant's Name/Relationship (Type, Print) ۵ Skip Jack Circle, Princess Anne, MD Charles Cotton/Son 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State portant: ury or oth -26-2009 Marion Station, MD John Wesley Cem Department Donation 5 Other Specify 22. Name and Address of Facility Bennie Smith 21. Signature of Funeral Service Liceus Isabella Salisbury. MD Funeral Home Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lier only one cause on each line. Hypertensive cardiovascular disease associated Approximate Interval Physician Between Onset and /Medical Death a with ablation procedure for uterine bleeding Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transi Physician/Medical 23a, PII, 27, permE, g896 10/26/09 TT X UNPENDED AMENDED The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day Year Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 V Unknown ⋧ Diabetes mellitus; obesity Completed Division of Vital Records, cate has been si page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed 2 No ✔ Yes 2 1 🗸 Yes After this certificate the Hospital or Attending Physician: 1 thin 24 hours after death. the Funeral Director: After this certific upletely filled in by the funeral director, p 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 DOA ER/Outpatient 3 ٩ 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27 Manner of Death Certification: 1 X Natural Yes 2 No 5 Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 Could not be Suicide or Town, State) within 24 hours at To the Funeral I Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 19, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner istrar's Signature State 31. Date filed (Month, Day, Year) ark SEP 2 Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2 109 445 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis <u>Anne Arundel</u> Medical Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Social Security Number **Funeral** Day, Year) 15,1939 Months Days Hours 1 □ M 2 🛛 F Washington, DC Director 70 J<u>une</u> 578-54-9306 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ite Madical Examinar must be notified at ury or other traumatic event, Ite Madical Examinar must be notified at 1 XYes 2 No Director Maryland Prince Georges Lanham 10g. Citizen of What Country? 10f. Zip Code 20706 U.S.A. 5502 Cordona St. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xlo Specify. If Yes Give à White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CSC Office Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha K. Kinsey James A. Clark ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 38173 Laurel Ridge Dr. Mechanicsville, MD 20659 John Doherty (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery Sept. 18,2009 Bladensburg, MD 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility 21. Signature Vuneral Service Licensee Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Uplation Physician unemia 12014 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and the detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, δ 1 Tes 2 No 3 Probably 4 Number 1 Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ∐Yes 2 DXJo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To nours after death.

neral Director: After this
y filled in by the funeral di 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day, Year) 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

within 2 To the I

24 hours

completely

31. Date filed (Month, Day, Year) State 1 6 2009

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Best gate Rd 10/cscy

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Svite 300 Annights

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death phonther 12 200 **Physician** 915 Richard Lassiter Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctors Community Hospital Lanham Prince Georges If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 245-62-8789 65 12/4/1943 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1

Yes 2 □ No Director MD Prince Georges Brandywine 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20613 United States 11851 Redwood Drive, West Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XiYes 2 □ No
If Yes, Give
Year or Dates: 1968-70 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bellehaven Country Club House Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Davis Lillie Lassiter ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert L. Myrick, Jr./Godson CMR 418 Box 3173, Apo, AE 09058 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Guilford Memorial 9/21/2009 Greensboro, NC 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Ineral Service Licensee 7400 Georgia Avenue, NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Examiner

Physician /Medical **Examiner**

Funeral

Director

Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at

Pages

death with the Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the luneral director, page 2 should be detached for use as the burial-transit Completed by Physician/Medical Be Certification: To

Division of Vital Records, P.O. Box 68760,

DTA

oragre 31. Date filed (Month Day, Year)

15 2009

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

R. Margarel AK fan 6/28 Landover

	Immediate Cause (Final disease or condition resulting in death)	a. Terminal Ma	lynart (youghours.	Onset and Death
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b			
ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ctopic pregnancy ther (specify)	23d. Date of o	delivery Day Year
leted by Ph	Part II. Other significant conditions	contributing to death but not resulting in the unde	rlying cause given in Part I.		to the cause of death? Probably 4 Horiknown autopsy findings available
				autopsy prior t performed? death 1 □ Yes 2 □ No 1 □ Ye	o completion of cause of
Be	25. Was case referred to medical examiner?			th (Check only one)	
	1 Yes 2√ Ne	Hospital: 1	3 ☐ DOA Other: 4 ☐ Nursing H	lome 5 ☐ Residence 6 ☐ Other (S	pecify)
ation:]	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	1	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred	
Medical Certification: To	3 ☐ Suicide 6 ☐ Could not to determined		factory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
dical (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	Physician: To the best of my knowledge, death or aminer: On the basis of examination and/or inves and manner stated.	ccurred at the time, date and place stigation, in my opinion, death occu	e, and due to the cause(s) and manner urred at the time, date and place, and d	as stated. lue to the cause(s)
Ž	29b. Signature and title of certifier		29c. License number	29d. Date signed (Mo	onth, Day, Year)

September 13 2009

DHMH 17 Rev 1/2001

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 11.2009 **Physician** 10:21M Timothy Mark Doudnikoff /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Center Joseph Medical 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, June 2, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Year) 1961 **Funeral** Days Months Hours 1 XM 2□ F 48 212-84-2769 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. and it item 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It is Medical Examinations. 1 ☐ Yes 2 No Director Mount Airy Maryland Howard 10g, Citizen of What Country? 10f, Zip Code 10e. Street and Number 21771 U.S.A. 1270 Ridge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☒ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Micrographics Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barry Basil Doudnikoff Bettv မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21771 Mount Airy, Maryland 1270 Ridge Road, Basil Doudnikoff - Father Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) Sept. 15, 2009 Silver Spring, Md. Gate of Heaven 22. Name and Address of Facility 21. Signature of Funeral Service Loenses Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): **Examiner** EWINGS SARCOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the HospItal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy Year Month 5 Other (specify) □Yes 2□No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 2**X** No RADIATION PNEUMONITIS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **N**0 1 □ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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1 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 11, 2009 **Physician** 10:23 AM Thomas Dean, Jr. Charles /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Queen Anne's Hospice of Queen Anne's,
5. Social Security Number | 6. Sex Centreville Inc. 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex ★ M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Delaware Months Days Hours 1935 73 18. Director 213-36-3844 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or Items 23a or 28a-f sho 1 ☐ Yes 2 ☐ XNo Director Ridgely Maryland Caroline 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States of America 21660 23039 Ninetown Road · death v Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Caucasian δ 3 Widowed 4 Noivorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farming Dairy & Grain Farmer 4 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyo, important: If item 27 is marked any injury or other to once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie Carol Marie Jackson Charles Thomas Dean, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 525 Green Crest Lane, Odenton, Maryland 21113 Son Charles T. Dean, III 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Denton, Maryland 9/15/2009 Denton Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. St nature of Funeral Service Lice is 22. Name and Address of Facility Moore Funeral Home, P.A. 100 12 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 415 disease or condition resulting in death) /Medical Due to (or as a consequence) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last July to for an a connectience of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) P.O. I cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 7 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the ft investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier i ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 30. Name and address of person who ause of death (Item 23a) (Type, Print) Som

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State Registrar 31. Date filed (Month, Day, Year) SEP 1 4 2009



State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 09-12-2009 10:50 AM AUDREY ROBERTA DeCHARD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Heritage Harbor Health & Rehab Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 DC 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Vear 1 ☐ M 2 🗓 F 02-28-1921 579-16-5038 88 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits a or 28a-f show 10c. City, Town or Location 10a, State 10b. County 1 XYes 2 □ No Director Marvland Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with Iral", or Items 23a 2700 South Haven Road 21401 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or flems 23: any injury or other traumatic event, ir and injury or other traumatic event, ir and once. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 White Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence E. Tvler William B. DeChard ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 932 Ships Bell Ct., Annapolis, MD 21401 Elaine Stevens/niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 X Cremation 3 Removal from State Riverdale, Maryland Riverdale Crematory 109-15-2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mary MO1374 Cedar Hill FH, 4111 PA Ave., Suitland, MD 20746 Hedgman Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (F disease or condition resulting in death) mediate Cause (Final **Physician** Cardiac Arrhythmia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Failure to thrive been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 sl autopsy performed? 1 Yes 2 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No after death Director: A in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral DI

completely filled in 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 09-15-2009 D57028 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 Ridgely Avenue, #231, Annapolis, MD 21401 Aditya Chopra, MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year, SEP 1 6 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** September 19, 2009 0859 A Ella Pauline Florian /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cecil E1kton Union Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 17, 5. Social Security Number 7. Age (In vrs. last birthday) Min. **Funeral** Months Days Hours 1 □ M 2 🗓 F North Carolina Yrs 66 215-42-1872 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Exprining Louel Exprining and once. 1 ☐ Yes 2 🗓 No Director E1kton Maryland Cecil 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number United States 21921 44 Willow Court Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify. If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: <u>Ş</u> White 3 X Widowed 4 □ Divorced Completed 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plastic Manufacturing Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Ella Mae Elliott Paul Walter Eldreth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21921 44 Willow Court, Elkton, MD Cynthia Dilks/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cherry Hill
Methodist Cemetery 20c. Location - City or Town, State 20a. Method of Disposition September 1 Burial 2 □ Cremation 3 □ Removal from State 23, 2009 Cherry Hill, MD 4 □ Donation 5 □ Other (Specify) 22, Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton 21. Signal re of Funeral Service Licensee 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending philosophers as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 2. No 1 ☐ Yes 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day, Year) Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 □Yes 2 □No within 24 hours after death,

To the Funeral Director: A

completely filled in by the fu 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 2☐ Medical Examine (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059501

State Registrar leted clus

NIAZ

32. Registrar / Signature

30. Name and address of person who come

31. Date filed (Month, Day, Year)

Muhamme

28 2009

of death (Item 23a) (Type, Print) College Ave.

			For State Registrar AMEND#7perF 1. Decedent's Name (First, Middle, Las	TH, 9-15-09, BMW	, Mo@e	rtificate of	Death		Reg. No.	Jus	3 0 3 L
	Physici		Mary Joseph					Sept.	2009	Year	10:55am
-	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, o	Location of Death		-	y of Death	1
			The Dove Hous			Westm				roll	
	Funeral Director		3/9-03-024/	ex	91 _{Yrs.}	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	179718	9. Birthp	place (State or Foreign ntry) , DC
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Mary a-f sh	ctor	MD Prince	George's U	niver	sity Par	rk				1 □Yes 2X No
	th with the 23a or 28	Funeral Director	10e. Street and Number 6717 44th Ave	nue		10f. Zip Code 2078	32		10g. Citizen of US	What Cour	ntry?
9800	should be filed within 72 hours after death with the Maryland ind Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 25a or 28a-f show umatic event, the Medical Evandant must be ruitfiled at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🛣 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Ra Bl	ace - Americack, White,	etc.
Maryland 21215-0036	vithin 72 h ane. I han "natu e Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Auditor	ation during most of work d)	ing	16b. Kind of I		_{dustry} Labor
d 2	Hygie Hygie other t		1. Father's Name (First, Middle, Last)		<u> </u>		18. Mother's Name	e (First, Middle	Maiden Surna	me)	
lan	fental fental rked c	To Be	Carmelo Milice				Angeli	na Ca	atalan	0	
Ž	nd 2 alth a 27 is 27 is		19a. Informant's Name/Relationship (Angela Bruce/D				and Number or Rui				
Baltimore,	permit. Pages 1 a Department of Hee important; if item any injury or othe once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	emetery, crer ort Li	esition (Name of matory or other place .ncoln	^(ce) 9/1	Date 1/2009		wood	,Md.
Balt	permit Depart Import any inj		21. Signature of Funeral Service Lies	nde,	P# 92	NTTPd ADVI 241 Colu	RINALDI mbia Bl	FUNER	AL SER ver Sp	RVICE	C,P.A. J,Md20910
it.	Physician		23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deat one cause on each line. Adult f				or respiratory a	rrest,		Approximate Interval Between Onset and Death OMO •
	/Medical Examiner	<u>.</u>		Due to (or as a conseq Dementi	a						2yrs.
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89	tificate ng phy as the	Medical		u							
.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	23c. If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of 0	al death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	ey .			ate of delive	very Day Year
rds, P.	luires that n signed t Ild be deta	by	Part II. Other significant conditions of Anemia, renal			nderlying cause giv	en in Part I.				the cause of death?
Records,	: The law requir cate has been s page 2 should I	Completed	•					24a. Was auto perfo	psy ormed?	o. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of
Vital	sician: The certificate I rector, page	Be C	25. Was case referred to medical examiner?	4			26. Place of Deat			(<u> </u>	2 🗆 100
of V	Physic r this car ral dire	၉	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐			4 Li Nursing H				_{ify)} hospice
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	Atten	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		ome, farm, str fy)		Yes 2□No	28f. Location (City or To	Street and Nur wn, State)	nber or Rur	ral Route Number,
_	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Ce	29a. Certifier (Check only one) 1 Certifying Properties (Check only one)	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	th occurred at the to	ime, date and place opinion, death occu	, and due to the red at the time	cause(s) and date and place	manner as e, and due t	stated. to the cause(s)
	To the within To the complex c	Me	29b. Signature and title of certifier	4		29c. Licens			29d. Date sign	ned (Month)	, Day, Year)
	15		Jan de 1	n/1 11	600	D3	5996		Sep	t.9,	2009
			30. Name and address of person who	compared cause of death (Iter	m 23a) (Type,	Print)		2.5		- 3	***************************************
			Linda Burrel			ersity	Blvd.W #	400 W	heaton	,Md	20902
	Sta Regist	ate rar	SEP 15 20	32 Registrar's Signature 1	5. Asa	aris					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Irving FELRICE September 12, 2009 1:35 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F Director 050-03-9845 May 17, 1915 New York Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Montgomery 1 □Yes 2 🕱 No Maryland Bethesda Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ns 23a or 4925 Battery Lane 20814 United States Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene.
The marked other than "natural", or items 23 and: If item 27 is marked other than "natural", or items 21 ury or other traumatic event, the Medical Exprinter must 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Chain Manager Grocery 18. Mother's Name (First, Middle, Maiden Surname)
Rose Schechter 17. Father's Name (First, Middle, Last) Be Benjamin Felrice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9500 Aspenwood Court, Montgomery Village, MD 20886 Joel Felrice, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 09/13709 permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance Memorial Park Clarksburg, MD 21. Signature of June al Sarvi e Licensee M01008 _22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 Qays Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction **Physician** /Medical Due to (or as a consequence of): Examiner Years Ischemic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Exami physician are the burial-tr Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) has been signed by the e 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? Anemia 24a. Was an autopsy performed? Yes 2 No certificate ha 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural (Month, Day, Year) 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 2 D 19294 September 12, 2009

State Registrar John R. Melnick, M.D., 911 Russell Avenue, Gaithersburg, MD 31. Date filed (Month, Day, Year)

SEP 15 2009

Registrar's Signature

SEP 15 2009

ress of person who completed cause of death (Item 23a) (Type, Print)

20879

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:08 P September 2 2009 **Physician** Alexander Ford Antonio /Medical 4c. County of Death Prince George's 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Clinton Southern Maryland Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | Washington DC 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 XM 2 □ F 29 Director 578-02-1724 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experiment must be notified at Capitol Heights Prince George's 1 X Yes 2 □ No MD Director 10g. Citizen of What Country? 10e. Street and Number USA 20743 4725 Quadrant Street Funeral death \ 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∏Yes 2 TYNo If Yes, Give Year or Dates: 1 ☐Never Married 2 ☐ Married Pages 1 and 2 should be filed within 72 hours after Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/ACollege (1-4or 5+) Elementary/Secondary (0-12) Unemployed 12th 18. Mother's Name *(First, Middle, Maiden Surname)* LaTanya Ford 17. Father's Name (First, Middle, Last) Be Unobtainable ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau 4725 Quadrant Street Capitol Heights, MD 20743 LaTanya Ford/ Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Washington National 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 9/11/09 Suitland, MD 4 Donation 5 Other (Specify) Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service License Briscoe-Tonic Funeral Home Tomi 2294 Old Washington Rd. Waldorf, MD. 20601 4mberlo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) 🌡 /Medical Due to (or as a consequence of): 1 week Examiner fected Arterul Veno Dudz rur Firt Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Exami physician and the burial-tran Due to (or as a consequence of): A nema seconary to hemory lage or hemotory Division of Vital Records, P.O. Box 68760, 1 week Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 ☐ Other (specify) I □Yes 2 □ No ate has been signed by the page 2 should be detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No 2 No certificate 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: DoA Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No nours after death.

neral Director: A

filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 24 hours a Hospital rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 0042609

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of

Silita 601 Clinton

use of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 735 AM **Physician** Fleming Robin 09 06-3009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Salisbury Coastal Hospice at the Loke Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🔀 F 85 243-22-5733 North Carolina 12/05/1923 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Expriner must be redified at once. 1X Yes 2 No Ocean City Director Maryland Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21842 145 Winter Harbor Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate agent 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zola Bradham McNeal Cottle ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zin Code)
13 Radcliff Dr., Rehobeth Beach, DE 19971 19a. Informant's Name/Relationship (Type. Print)
Gil Fleming/son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 9/10/09 Salisbury, MD Salisbury Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Lice 16.USC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DISRASR ARTRRY **Physician** CORONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): PNRUMONIA Examiner PIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed SEP515 attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) icate has been signed by the ; page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 THO 1 ☐Yes PENO certificate 26. Place of Death (Check only one) director, Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1+0591CR 1☐Yes 2☐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this s after death.
I Director: After this of in by the funeral di 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide within 24 hours aft To the Funeral Di Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier è D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 130 X Humm 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Fields Richard Woodrow /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number 9. Birthplace (State or Foreign f Under 24 Hrs 8. Date of Birth (Month) Day, Year) 03/02/1913 If Under **Funeral** Days Hours Months 1**x** M 2 □ F 96 Maryland 216-12-1963 Director Usual Residence of Decedent hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examinar in ust be notfilled at 1 ¥ Yes 2 □ No Salisbury Maryland Wicomico Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21801 603 Crestview Lane Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: white Specify: 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 Elementary/Secondary (0-12) Health and Mental Hygiene. em 27 Is marked other than College (1-4or 5+) 12 jeweler jewelry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Pansy Elizabeth Smith Harry Matthew Fields ပ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Amherst Rd., Salisbury, MD 21801 permit. Pages 1 and 2 a Department of Health au Important: If item 27 Is any Injury or other trau Jane Fields/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/13/09 Salisbury, MD Wicomico Memorial 4 ☐ Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral Service Licensee 22 Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final estive Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to increase acase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Junto (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) □Yes 2□No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 PNo Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 ∐Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Y 5000 C 30. Name and address of person who comple ted cause of death (Item 23a) (Type, Print) Salisbury Md 21804 · Division 1t. + cke Year) 31. Date filed (Month, Day, State SEP 2009 Registrar

DHMH 17 Rev 1/2001

			State of Maryland 1 - State Amended item#11,WCHD,SLU,9.	d / Depa 10.09,	rtment of F	lealth ar Death	nd Mer	ntal Hyg	jiene	0.0		25	
			1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last)					2. Date of Death 3. Time of Death					
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-ele ^(g) -	1		27031 Pemberton Drive  5. Social Security Number 6. Sex 7. Age (In yrs. In	ast birthdav)	Sali If Under 1 Year	sbury	Hrs. 8.	Date of Birth		9. Birthp	lace (State o	or Foreign	
	uneral rector		452-34-6711 1 M 2 X F 81	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day 9/10/1	, Year) . <b>927</b>	Texa	itry)		
pu	3	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City	, Town or Lo	ation					1	0d. Inside Cit	tv Limits	
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the l	and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medic I Examinat must be redified at	Director	10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?				
th wit			27031 Pemberton Drive		21801				USA				
21215-0036 d within 72 hours after dea giene.		by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ♣ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	l l	13. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ric  1 □ Yes 2 No Specify:				No- 14. Race - American Indian, Black, White, etc.  Specify: White				
<b>5-6</b>	natur	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	edent's Usual Occupation re kind of work done during most of working				16b. Kind of Business/Industry				
727 within	than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		e kind of work done during most of working DO NOT use retired) Sewife				domestic				
land 2	1 10 20 10	To Be Co	17. Father's Name (First, Middle, Last) Rowland C. Wilson		18. Mother's Name (First, Middle, Maiden Surname)  Jewett Thayer								
Et 2			19a. Informant's Name/Relationship (Type. Print)  Laurie Nosworthy/daughter		g Address (Street ) 98 McLey								
altimore, rmit. Pages 1 ar partment of He≀	if Item or other				sition (Name of natory or other plac		Date		20c. Location	•	•		
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Dermi Depa	physician and injury or any in		21. Signature of Funderal Service Licensee 22 Honograph Address of Facility at Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804										
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Approximate Interval Between Onset and Death Mctastate Mclanoma 2 y (ars.										
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<b>68</b> /	ig phy: as the	ledic	d			- 1							
O. BOX 6 the death certifi	ate has been signed by th page 2 should be detache	Physician/Me	FEMALE: b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnant at time of death 5   Other (specify)   9   Unknown					23d. Date of delivery  Month Day Year			/ear		
ords, P.O		þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown				
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<b>OT VITAI</b> Physician: ⊺		Be C	25. Was case referred to medical examiner?  26. Place of Death (Check only one)										
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on ding		ıtion	1	Injury	of 28c. Injury at 28d Work?  M 1 □ Yes 2 □ No			8d. Describe how injury occurred					
UIVISION al or Attending s after death.		Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At he building, etc. (Specify)	me, farm, stre				Street and Number or Rural Route Number, vn, State)					
<b>ne Hospit</b> า 24 houณ		edical (									;)		
To th	To tl	Me	29b. Signature and title of certifier		29c. Licens				29d. Date sign				
1/5	Al RR		www. w. h			57359			Angu	st 915	200	9.	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DA - USHA NATES AN 1415 - S-DIVISION ST, SALISBURY NO 21804  31. Date filed (Month, Day, Year)  SEP 10 2003  32. Tegistrar's Signature  A market										
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DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla	•	artment of F tificate of I		entai Hygie Reg.		51006		
	Physicia	an	1. Decedent's Name (First, Middle, L	· ·	0	. 11		2. Date of Death Month	Day Year	3, Time of Death		
11	/Medical		Charles  4a. Facility Name (If not institution, g	<u> </u>	Gro	ssnickle	r Location of Death	eptembe	4c. County of Death	8:45P		
	Examin	er	Fahrney-Keedy Ho			Boonsb			Washingt	on		
	Funeral Director		213-18-8518	. Sex 7. Age ( <i>In yr</i> s 1	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.     Hours   Min.	8. Date of Birth (Month, Day, Ye Seb. 25,	ear) 9. Birth Cou 1916 Mary	place (State or Foreign ntry) yland		
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	cation			1	10d. Inside City Limits		
	a-fsh		Maryland Washin	ngton	Boonsbo	ro				1 ☐ Yes 2√ No		
	or 28	Director	10e. Street and Number	D 1		10f. Zip Code	1.0	10g	Citizen of What Cou	ntry?		
	eath w	Funeral	8507 Mapleville  11. Marital Status	12. Was Decedent Ever in t	U.S. 13	217		cify Yes or No-	USA 14. Race - Ameri	can Indian.		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Madical Evantment in at the matth of once.	by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	1	fYes, specify Cuba 1 □Yes 2 <b>K</b> INo	lispanic Origin? (Spe an, Mexican, Puerto F Specify:		Black, White, Specify: Whi	etc. Lte		
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<u>₹</u>	should thank markers markers	은	19a. Informant's Name/Relationship			A ddu (C44			ity or Town, State, Zi			
<u>≅</u>	and 2 sl ealth an n 27 is r		M. Ellen Catlett						Maryland 2			
Baltimore,	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Linemovar irom State   Cr	Place of Dispo cemetery, cree Cossnicl	sition (Name of natory or other place Le Breth	ren Sept.2		c. Location - City or To Iyersville			
Balti	permit. Departr Importa any Inju		21. Si mature (f Funir Liber c) Lic			2. Name and Addre	ss of Facility uneral Hor		lain Stree ville, MD			
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g, F	w requires that the described by the should be detached							co use contribute to the cause of death?				
B · の I Records,	law as b	Completed by						24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of		
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V	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate hompletely filled in by the funeral director, page	Medical		Physician: To the best of my k xaminer: On the basis of exami and manner stated.		nvestigation, in my	opinion, death occurr	ed at the time, date	e and place, and due	to the cause(s)		
	To t with To 1	Z	29b. Signature and title of certifier	mha		29c. Licens	60396		- 7 1. 11	, Day, Year)		
_	10		30. Name and address of person with ARID	ho completed cause of death (It	em 23a) (Type,	Print) 11	126 0	pal	ctmo	21740		
	Sta Registr		31. Date filed (Month, Day, Year) SFP 28 2009	Seneua 8.	A COLLEGE	1	100	-	N			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPT. 16 Pay 2009 Year **Physician** NANCY CAROL GRAHAM 1:45A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CHARLES 11914 NEALE SOUND DRIVE COBB ISLAND If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign WIS • 8. Date of Birth Month Day Year 8-15-1932 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Hours Days 579-42-8481 77 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ms 23a or 28a-f show 1 □ Yes X No COBB ISLAND MD. CHARLES Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20625 11914 NEALE SOUND DRIVE U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Hems Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? th and Mental Hygiene. 7 is marked other than "natural", or fter traumatic event, the Middon Exariand. 1 ☐ Yes 2 ☐ MANo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ò SpecifyWHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUIS EDWARD DREYER SARAH MARIE SPEER 2 19a. Informant's Name/Relationship (Type. Print)

19b. Phailing Agres X Streeging Number or Rural Route Number, City or Town, State, Zip Code)

ROBERT E. GRAHAM, SR.-SPOUSE 11914 NEALE SOUND DR. COBB ISLAND, MD. 20625 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and :
Department of Health
Important: If item 27
any injury or other tr.
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RAYMOND FUNERAL SI
LA PLATA, MARYLAND M00479 21. Signature of Funeral Service Licensee. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

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To the Fune

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State

Registrar

31. Date filed (Month, Day, Year)

28 2009

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5,&16a&b Per FH G896, 10/26/09 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** NOAH FARRALL GURSKI 11:00 A^M SEP 16 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, **Funeral** 5. Social Security Number 579–49–7201 6. Sex Date of Birth (Month, Day, Year) Hours Months Days Min. 1 🔀 M 2 🗆 F Director 09/14/2009 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Examiner must be notified at VA Loudoun Sterling 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 18 Glengyle Lane 20165 USA items 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or If Yes, Give Year or Dates 1X Yes 2 □ No Specify: Mexican Specify: White 9 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation within 72 (Give kind of work done during most of working life. DO NOT use retired) ul Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, Its once. Infant Infant 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Steve Gurski, III Colleen Mei-lin Farrall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve Gurski, III - Father 18 Glengyle La., Sterling, VA 20165 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Quantico National 09/23/2009 Triangle, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 721 Elden St. 21. Signature of Funeral Service Licen wm Herndon, VA 20170 Adams-Green Funeral Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PREMATURITY /Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the death certificate be executed that initiated events resulting in death) Last physician and s the burial-trans Box 68760, 53 Due to (or as a consequence of) Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' certificate 1 ☐Yes 2 ☐ No 1 ☐Yes 2 🗆 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1X Inpatient this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number AFE75511 (CA) 09-17-2009 MO 30. Name and addre In who completed cause of death (Item 23a) (Type, Print) 5 NATIONAL NAVAL MEDICAL CENTER JASON DYHIGGINSON LCDR MC BETHESDA MD 20889-5600 USN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

00.01210	Please Type of Print in black indelible ink. Ensure All Copies Are Legible.	
Dewayne Calvin Grieves	State of Maryland / Department of Health and Mental Hygiene	
1- For State	Certificate of Death Reg. No.	

		- For State Registrar		Cei	rtificate of	Death		Re	eg. No.	009 3	1100
Physiciar Medical Examin	1/	<ol> <li>Decedent's Name (First, Midd)</li> </ol>	_{le,Last)} Grieves					2. Date of Dea Month Septembe	th Day Yea er 16, 2009	3. Time of 0 2209 h	
J.		4a. Facility Name (if not institution Northwest Hospital	n, give street and n	umber)	4	b. City, Town, or Li Randallstowr			4c. County Baltimo	of Death re County	
Funeral Director		5. Social Security Number 216-96-6991	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min	-	th(MM/DD/YYY) 3/1964	7) 9. Birthplace (State Country) Mary1a	
w any	-	Usual Residence of Decedent  10a. State 10b. County			, Town or Locati					10d. Inside	
Maryland 28a-f show	Director	MD Balt  10e. Street and Number	imore		Owings	10f. Zip Code		1	0g. Citizen of W		2No
with the Maryland ms 23a or 28a-f she be notified at once		4609 Wards C			0 140 11	21117		Van an Na	U.S.A.		Disale
er death	by runeral		arried Armed In 1 X Yes vorced If Yes, Give Yes	2 No ear 1989	If Y	s Decedent of Hispes, specify Cuban, Yes 2 X No	Mexican, Puerto		Whit	e-American Indian, E e, etc. White	SIACK,
2 hours "natur		15. Decedent's Education (Spe Elementary/Secondary (0-12)		ade completed) (1-4 or 5+)		's Usual Occupationst of working life. I			16b. Kind of Bu	usiness/Industry	
5-0036 led within 72 tygiene. other than '	Completed	12 17. Father's Name (First, Middle		,	journ	neyman n			sheet	t metal	
21215-0036 Duld be filed within 7 Mental Hygiene. Imarked other than ic event, the Medica	<u>ا</u> ۾	Frank W. Gri	eves, S	r.		5	Shirley	Morr	al		
MD 21 d 2 should d 2 should Ith and Me an 27 is ma	- 1	19a. Informant's Name/Relations Deborah Grie		wife	4609	Wards	Chappe	Rural Route Nur	Owings	vn, State, Zip Code) S Mills , İ	MD
G E E E	1	20a. Method of Disposition  1 Burial 2 X Cremation		from State	crematory or oth	tion (Name of cemer er place) and Cren	1107	Date 20/09		-City or Town, State erland, I	
Baltimore, permit. Pages I as Department of He Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service						ırst Fı		Home P. 4D 21532	
Physician	+	23a. Part I. Enter the disease, or	complications that	caused the death						eart Approxim	ate Interval
/Medical `xaminer		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a Head	neck a		o injurie	es				Onset and leath
- with	ا _ا	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence of	of):					-	
ansit		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of	of):			<del></del>			
50, te be executed ysician and burial - transit		X UNPENDED	d AMENDED	23a,27	,28a-f,	perME, g8	896 10/2	2/09 TT			
Ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed retor. After this certificate has been signed by the attending physician by the function of the control of the con		IF FEMALE: 3b. Was decedent pregnant in the past 12 months?	he 1 Live	, outcome of preg birth	₂ Fe	al death 3	Ectopic pregna	ancy	23d. Date o Month	f delivery Day	Year
P.O. Box 68 s that the death certigened by the attending detached for use a	L) SICI		known g Unkr	nant at time of de	eath 5 Ot	ner (Specify)					
P.O. es that the grand by be detach		Part II. Other significant condi	tions contributing	to death but not r	resulting in the u	nderlying cause gi	ven in Part I.			ribute to the cause of Probably 4	1
of Vital Records, P  ng Physician: The law requires t  nder this certificate has been sign  nder this certificate has been	Completed by							24a. Was auto perfo	psy	Were autopsy finding prior to completion o death?	
1 of Vital Recling Physician: The I After this certificate I funeral director, page		25. Was case referred to medica				26.Place	of Death (Check	1 ✓ Yes only one)	2 No	1  Yes 2	No
Vite or I direc	o ne	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	Other: Nursii	ng Home 5	Residence 6	Other:	-
sion of trending Ph death.  ctor: After ty the funeral		27. Manner of Death  1 Natural 5 Pen	ding 0/16	e of Injury Ih, Day,Year)	28b. Time of 1	1 1 v	yatWork? es 2 ∑No		how injury occur fell do	own stairs	3
Division pital or Attendio ours after death. erral Director: A	Certification:	3 Suicide 6 Cou	ld not be 28e. Pla			t, factory, office bu	uilding, etc.	28f. Location (	Street and Numb State)4609 Mills,	ver or Rural Route No Wards Cha	umber, City pe1 Rd
	<u>ē</u> [		hysician: To the be iminer:On the basis	est of my knowled s of examination a				d due to the cau	se(s) and manne		
To wir	<b>a</b> E  -	29b. Signature and title of certific	and manner er	stateu.		29c. License			1	ned (Month, Day, Yea	ar)
		30. Name and address of persor	who completed car	use of death (Iten					Coptombe	, 2000	
Star	e		sistant Medical	Examiner Registrar a Signat		treet, Baltimor	re, MD 2120	1			
Registra	ar	31. Da SEP 218 2009	renau	p. 14	GFS/ CO						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

For **Physician** /Medical Examiner **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventher must be motified at once. Be Completed by Funeral Director Baltimore, Maryland 21215-0036 ဂ္ Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	-	– State Registrar					Cer	tificate of i	Death			Reg. No.		, )	
		1. Decedent's Name	e (First, Middl	le, Last)							2. Date of De Month	eath Day	Yea		ne of Death
ysicia		Arthur Jo	hn Gui	ider							09/09/		Tea		44 P M
Medic: camine				n, give street and nu	um <i>ber</i> )			4b. City, Town, o	r Location o	of Death	·	4c.	County of De	12;44 P M   Ounty of Death   Cester   9. Birthplace (State or Foreign Country)   MA   10d. Inside City Limits   1   Yes 2   No en of What Country?   4. Race - American Indian, Black, White, etc.   Specify: White   d of Business/Industry   enforcement   Surname)   Town, State, Zip Code)   MD 21842   ation - City or Town, State   kford DE   neral Home   11   Approximate   Interval Between   Onset and Death   Onset and Deat	
amm	<del>-</del> 1			al Hospita				Berlin				Wo	rceste	r	
neral		5. Social Security N		6. Sex		(In yrs. last birth	nday)	If Under 1 Year	If Under	24 Hrs. Min.	8. Date of Bir	rth	9. B	irthplace (St	ate or Foreign
ector		025-34- 8	3670	1√ M 2□ F	63	Y	rs.	Months Days	Hours	IVIII I.	5/4/19	46			
	ı	Usual Residence of	Decedent												
텉		10a. State	10b. County	•	1	Ioc. City, Town	or Loc	ation							•
pat	ig	MD	Worce	ster		Ocean C	ity	7						1 1 1	Yes ZYEINO
100	Director	10e. Street and Nur	mber					10f. Zip Code				10g. Citi	zen of What (	Country?	
at De		10301 Irc	n Cate	Court				21842				USA			
Ē	Funeral	11, Marital Status	n oace	12. Was Dec	edent Ev	er in U.S.	13. V	Vas Decedent of H	lispanic Ori	igin? (Sp	ecify Yes or No	0-			ın,
any injury or other traumatic event, the Medical Examiner must be notified at once.	교	1 Never Marr	ied 2 🔀 Mar	ried Armed F	2 □ No live			Yes 2 No			Thours oto.				
Exar	by	3 🗆 Widowed	4 Divorced	Year or I	Dates:		'	Lies ZLANO	эрвыну.				Specify: W		_
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2	Ö			4			ic€	officer	_					cement	
/ent	Be (	17. Father's Name	(First, Middle,	, Last)					18. Mothe	er's Nam	e (First, Middle	e, Maiden	Surname)		
tic e	To E	Walter Ja	ames Gu	ider					Blanc	che :	10g. Citizen of What Country?   USA				
Ē	-	19a. Informant's N	ame/Relations	ship (Type. Print)		19b.	Mailin	g Address (Street	and Numb	er or Ru					
er tra		Joan M.	Guider	(wife)		10	301	l Iron Ga	ate Co	USA					
otio		20a. Method of Dis	position					sition (Name of natory or other pla	Second   S						
5 ^		1 ☐ Burial 2 4 ☐ Donation		3 ☐ Removal from	n State			open Crer	i .	9/10	/2009	10d. Inside City Limits   1   Yes 2   No     10g. Citizen of What Country?     USA   14. Race - American Indian, Black, White, etc.   Specify: White     16b. Kind of Business/Industry     Law enforcement     Middle, Maiden Surname     Spearin     Number, City or Town, State, Zip Code     an City, MD 21842     20c. Location - City or Town, State     9			
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cal ner				Due to	o (or as a	consequence o	of):								
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	Physicia			tions contributing to	death but	not resulting in	the III	nderlying cause gi	ven in Part	l.	23e. Did	I tobacco	use contribute	e to the caus	e of death?
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ž Ž		25. Was case refe	rred to medica	al					26. Plac	ce of Dea					
	o Be	examiner? 1 ☐ Yes 2	UNo	Hospital:	1 Innatier	nt 2 🗆 ER/Ou	tpatier	nt 3 DOA Ot	her: 4□N	Jursing H	lome 5 ☐ Re	sidence	6 □Other (5	Specify)	
	Ë	27. Manner of Dea		28a. Dat	te of Injury	y 28b. 7	Time of	f 28c. Inju	ıry at						
	ţ	1 Natural 2 ☐ Accident	5 ☐ Pendi invest	ing (Mo tigation	onth, Day,	Year)	njury			No					
	lica	3 🗌 Suicide	6 Could	minod 200, Flat	ce of Injur	y - At home, fa	rm, str	eet, factory, office						r Rural Route	e Number,
	Certification: To	4  Homicide	deter	buil	lding, etc.	(Specify)					City or I	own, Stat	e <i>)</i>		
filled		29a. Certifier	Certify	ring Physician: To t	he best o	f my knowledge	e, deat	h occurred at the	time, date a	and place	e, and due to the	ne cause(	s) and manne	er as stated.	
completely filled in by the funeral director, page 2 should be detached for u	Medical	(Check only one)	2☐ Medica	al Examiner: On the	basis of anner stat	examination an	d/or ir	vestigation, in my	opinion, de	eath occu	urred at the tim	e, date ar	nd place, and	due to the ca	ause(s)
mpk	Mec	29b. Signature and	d title of certifi	-				29c. Licen	se number	,		29d. D	ate signed (M	onth, Day, Y	ear)
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1-1		30. Name and add	/	n who completed ca	use of de		(Type,		۱- سرما ا	u b	r. Be	·lin	MD	2181	1
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Sta egistr		or. Date ⊓eα (Mo		4 2009	indistra	M. A.		60. 4.1						American Indian, White, etc. White  ate, Zip Code) 1842 by or Town, State  d DE 1 Home  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Of delivery h Day Year  ate, Zip Code)  (Specify)  Tor Rural Route Number, Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death	
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DHMH 17 Rev 1/2001

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_			For State Registrar	State of Marylan		epartment o Certificate d				giene Reg. No. 20	69	31041
	Physici		Decedent's Name (First, Middle, La  Amelia Jon	st) <b>Garrison</b>					2. Date of De Month	Day		3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, gives 5. Social Security Number 6. S	e street and number)  A + the Lak  Sex 7. Age (In yrs.		Sal If Under 1 Ye Months Da	isbo	nder 24 Hrs.	8. Date of Bir	4c. County of the lay, Year)	Approximate Interval Between Onset and Death  Date of delivery Month Day Year	
	rland ow		Usual Residence of Decedent  10a. State 10b. County	## At the Lake and the property of the propert								
	Providing   Prov		1 □Yes 2 No									
	Property    ry?											
	ns 23	eral			S.			c Origin? (St	pecify Yes or No			n Indian.
ر با 0036	ours after d ural", or iten		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1 □Yes 2 <b>X</b> □	No Spe		Rican, etc.)	Specify:	white, et White	c. Lte
Sen 15-00	in 72 h "natu	olete	(Specify only highest gra	ade completed)	16a. [	Decedent's Usual Oc (Give kind of work do life. DO NOT use re	cupation ne during tired)	most of worl	king V	16b. Kind of Bus	siness/Indi	ustry
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Z Z	hould Id Mer marke matic	욘			10h	Mailing Address (Ctr	Second   S					
	nd 2 s alth an 27 Is rrtrau								Ac. County of Death   Ac. County of Death			
Amelia.	Pages 1 a ment of He ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	20b. F	Place of I cemetery Ster	Disposition (Name of crematory or other <b>n Shore</b>		1	Date	20c. Location - 0	City or Tov	
A P	permit. Depart Import any Inj		1 Steirs	Jamell	1	22. Name and Ac Parsell Clarksv	Func ille	acility eral E Chape	nterpri 1, Ocea	ses, Inc n View,	•	.9970
	/Medical	ir	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. SBPS ( Due to (or es a conseq b.	uence of	<b>)</b> ;	dying, suc	h as cardiac	or respiratory a	rrest,		Interval Between
,8760,	icate be executed physician and the burial-transit	Examin	that initiated events	C								
Box	= O1 cc	hysician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	death							•
	equires tha sen signed ould be det	þ	Part II. Other significent conditions of	ontributing to death but not resi	ulting in t	the underlying cause	given in F	art i.				
ital Reco	ian: The law r rtificate has be stor, page 2 sh		25. Was case referred to medical				26. F	Place of Dea	autoj perfo 1 □ Yes	psy primed? do	rior to com eath?	pletion of cause of
ion of V	nding Physic uth. r; After this ce e funeral direc	၉	1  Yes 2  No  27. Manner of Death Natural 5  Pending	28a. Date of Injury (Month, Day, Year)	28b. Tii	me of 28c. I	Other: 4[ njury at Vork?	☐ Nursing H	ome 5 ☐ Resi	dence 600the		Hospica
Divis	ital or Atte urs after dea ral Directo		3 Suicide 6 Could not be determined	building, etc. (Specif					City or To	wn, State)		
	e Hosp 124 hou e Fune letely fi	dical	(Check only / 2 ☐ Medical Exar	niner: On the basis of examina	wledge, ition and	death occurred at the or investigation, in n	e time, da ny opinion	te end place , death occu	e, and due to the rred at the time,	cause(s) and ma date and place, a	nner as stand nd due to	ated. the cause(s)
	To the vithin To the comp	Me	29b. Signature and title of certifier									
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			SEP 10 20	109 Carriegistrar's Signa	d. ,	back						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

rrence Gree	#11		For State	e or iviaryianu /		ate of				Reg. I	No.	200	19 3101
Physi	Lare 3-5-0036  and be filed within 72 hours after death with the Maryland and Briginer and the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		egistrar . Decedent's Name (First, Middle,L	ast)						Date of Death Month Da	y Ye.		3. Time of Death 2016 hrs
edical Exa	min		Terrence	Green, Sr.		- I al-	City Town	, or Location of		eptember 1	0, 2009 4c. County	of Death	20101113
		4	a. Facility Name (if not institution, e Prince George's Hospita			46	Cheverly		Death		Prince (		s
Funer	al	5			e (in yrs. last bi	rthday)	If Under 1		24Hrs. 8.	Date of Birth (	MM/DD/YYY	Y) 9. Birth	place (State or Foreign
			215-25-6459	X M 2 F	29	Yrs.	Months	Days Hours	Min. I	Dec. 13	, 1979	Was	hington,D.C
			Jsual Residence of Decedent		10c. City, Tow	n or Locatio	nn						10d. Inside City Limits
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2121 ould be fil Mental I	c even		19a. Informant's Name/Relationshi							al Route Number			
MD d 2 sho lith and n 27 is	umat		Denise Green /	Wife						ldorf,		20603	Town, State
ore, sland of Heal of Iten	er tra		20a. Method of Disposition  1	3 Removal from St	ate crem	natory or oth						•	
imo Page ment c	or of	- 1	4 Donation 5 Other Spe	Ary:	Har		Memori				Lando		
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	/Medical		failure. List only offe cause of Immediate Cause (Final disease	_{a.} Asphyxia									Death
Admin	_		or condition resulting in death)	Due to (or as a cons	equence of):								
	ı	ĕ	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):								
	-	amir	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):					-			
outed nd	transit		events resulting in death) Last	d									<u> </u>
) oe exec	rial -	dica	UNPENDED	AMENDED							Tarin		
760 ficate   g phys	the bu	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregnar		etal death	3 Ectop	ic pregnanc	су	Month	of deliver	y Day Year
× 68 th certi	use as	iciai	past 12 months?	4 Pregnant a	at time of death	_	ther (Specify	1)					
Bo he deat	hed for	Phys	Yes 2 No 9 Unki	9 Onkilowii	th but not resu	Iting in the	underlying c	ause given in F	Part I.	23e. Did tob	acco use co	ontribute to	the cause of death?
P.O.	be detached	þ	Part II. Other significant conduc	ons continuing to dea	ill but hot resu	ining in the	o	<b>3</b>		1 Yes	2 🗸 No	3 Pro	bably 4 Unknown
rds, require	should b	Completed							_	24a. Was a		b. Were a	utopsy findings available completion of cause of
e law r	5 67 F	mpf								perform	ned?	death?	
tal Rections The	ector, page		25. Was case referred to medical				26	.Place of Deat	h (Check or	nly one)			
Vita hysicia	ੂੰ ਦੇ	o Be	examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpai	ient 2 🗸 El						Residence		er:
n of Ing Pt	funeral	n: T	27. Manner of Death  1 Natural 5 Pend	28a. Date of Ir (Month, Day Sep 10, 200	njury 2	8b. Time of 1000 hrs		c. Injury at Wo	[9	28d. Describe h Subject hang		curred	
Sior Attend	in by the	catic		tigation	Injury - At hom	e farm stre				28f. Location (S	treet and Nu	ımber or R	Rural Route Number, City
DIVI	led in	Certification:		not be	ingle Famil					or Town, S 504 Insey Str	ate) eet, Distric	t Heights	s, MD
Divisior To the Hospital or Attend within 24 hours after death.	completely filled in by the funeral		29a. Certifier	ysician: To the best of	my knowledge	, death occi	urred at the t	me, date and	olace, and o	tue to the caus	e(s) and mai	nner as sta	ated.
To the	omple	Medical		miner: On the basis of ex and manner state	kamination and d.	or investiga				the time, date			Ionth, Day, Year)
		ž	29b. Signature and title of certifie	1	- 0 -	0.1	1	License number O.C.M.E.	51		Septem		
			Collect		POR. A		/		<u>.</u> .				
R G			30. Name and address of person Zabiullah Ali, M.D.	who completed cause o Assistant Medical	Examiner	111 Pe	nn Street	, Baltimore	, MD 212	201			
V	s	tate											
Re	egis			(business	a. Ma	VIII.							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Ve ar 2:31AM **Physician** local /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner oellman eorges If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 👿 F 49 -018 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b 1 Xves 2 □ No ral", or items 23a or 28a-f sh Examinar must be redified **Funeral Director** Kon 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number # permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Exemitrar must be resonne. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 🖫 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) abt 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Nymber, City or Town, State, Zip Code) 70 745 19a. Informant's Name/Relationship (Type: Print) 5pouse Oxontill 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ametory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fac 21. Signature of Funeral Service Licenses 9908 10 20721 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical signed by the attending p IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part JL-Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ► No 24a. Was an autopsy performed? Yes 2 No has certificate 1 □ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: Hospital: 2**¹**□No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Tes 1 Inpatient Certification: To After this 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident in by the 24 hours after deatl 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 30. Name and address of

31. Date filed (Month, Day,

1 6 2009

n who completed cause of death (Item 23a) (Type, Print)

		For	State of	of Marylar					nd M	ental Hy	giene			01011	
		Registrar	( cot)		Cer	tificate	or De	eatn				نالاي	7	31044	
Physicia Medic												/ Year		7:24 Рм	
Examin	er			nber)					Death						
Funeral Director				7. Age (In yrs. I	last birthday) Yrs.	If Under Months			4 Hrs. Min.	8. Date of Bird	th 1910				
ind show at	o.	Usual Residence of Decedent  10a. State 10b. County	Certificate of Death Property Prof. (Account. Last)  Orence J. Hofferber  Inty Name of not eachtone, pies shore and number)  Stanford Road  18 Security Name of the County of Death Hagers Stown  18 Security Name of Death Hagers Stown  19 Stanford Road  10 M 2 IX P 99  10 County  10 County  10 Stanford Road  10 County  10 Count												
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s after death al", or item Examiner m	þ	11. Marital Status  1 Never Married 2 Marr  3 XWidowed 4 Divorced	Armed Formed 1 Tyes If Yes, Given	orces? 2 💢 No ve	l II	f Yes, specif	y Cuban,	Mexican,	n? (Spec Puerto F	cify Yes or No- Rican, etc.)		Black, Wh	nite, etc	S.	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed		t's Education of grade completed College (1	)	(Give F life, D	kind of work O NOT use	done dur etired)		of workir	2. Date of Death    Sont   1-2009   Year   7:24   P m					
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Physician/			nly one cause on ea	ach line.					ardiac o	respiratory ar	rest,		1	nterval Between Onset and Death	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ※No 9 ☐ Unknown	1 Live	Birth 2 Fet	al death 3 🗌										
res that the signed by	by	Part II. Other significant condition	ns contributing to o	death but not res	sulting in the u	inderlying ca	use giver	n in Part I.							
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ysicis is cer direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatien	nt 3 🗆 DO.	Other:	4 🗆 Nur	sing Ho	ne 5 Resi	dence 6	Other (Sp	ecify)		
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the Host nin 24 ho the Fune	Medical	(Check 2 Medical E only one) 3 Certifying	xaminer: On the ba	sis of examinatio	n and/or invest	tigation, in m	y opinion,	death occ	curred at	the time, date a	and place,	and due to th	e caus		
To t To t		29b. Signature and title of certifier	Phys	8 on	1				4		29d. Dat	e signed (Mo	Black, White, etc.  Decify: White  It of Business Industry  ty Government  Imame)  Down, State, Zip Code) Ind 21702  Ind 21702  Ind 21701  Approximate Interval Between Onset and Death Interval Betwe		
15			vho completed cau	_		7 T4	mus	Juho	1567	De.	All Was an autopsy performed?  All Was an autopsy performed?  All Was an autopsy performed?  All Were autopsy findings available prior to completion of cause of death?  All Was an autopsy performed?  All Was an autopsy performed?  All Were autopsy findings available prior to completion of cause of death?  All Were autopsy findings available prior to completion of cause of death?  All Was an autopsy performed?  All Were autopsy findings available prior to completion of cause of death?  All Was an autopsy performed?  All Wa				
Stat Registra		31. Date filed (Month, Day, Year)		Registrar's Signa		6		Its. Mother's Name (First, Middle, Malden Surname)  Myrtle  Itreet and Number or Rural Route Number, City or Town, State, Zip Code)  haven Frederick, Maryland 21702  of ar place)  Oetar Date  20c. Location - City or Town, State  Cem. 9-26-2009 Cedar Rapids, Iowa  Address of Facility Keeney & Basford P.A.F.H  t Church Street Frederick, MD 21701  of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death  3							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			For State Registrar	State	of Marylar						-	3 101.
	Physicia	20	1. Decedent's Name (First, M								Year	3. Time of Death
				<u> </u>			41 O'1 Town					
	Examin	er			umber)						*	
Discourage Name (First, Models, Last)   Discourage Name (First, Models, Last)   Discourage Name (First, Models, Last)   State of Discourage Name (First, Models, M		nplace (State or Foreign										
h.			094–16–8425	13 <b>€</b> M 2 ☐ F	87	Yrs.	Months Days	Hours Min.	July 10,	^{9,} 1922	New	York
	and w				10c. C	itv. Town or Lo	cation					10d. Inside City Limits
	Maryla f sho	ρ		,								1 ☐ Yes 2 🔼 No
	r 28a	irec	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	untry?
	th with	a D	14400 Homecre	st Road, #221			20906			USA		
	r dea	nuel		Armed F	orces?	J.S. 13. \	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No Rican, etc.)	)- 14. Ra Bla		
36	rs afte					46	I∐Yes 2⊠No	Specify:		Spec	ify: Whi	te
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	nd 2 salth a					1420	l Manorval	e Road, Roci	kville, M	ID 20853		
=	es 1 a of He of He rothe		·	0 1971 D 1 4	20b.	Place of Dispo cemetery, crer	sition (Name of natory or other pla	ace) Sont		20c. Location	n - City or	Fown, State
Ē	Page ment ant: I				Pr Pr	ospect H	ill Cemete	ry 20	09	Glovers	ville,	New York
Balt	permit Depart Import any inj once.		21. Signature of Funeral Serv	vice Licensee	2	5 5	Name and Addr rancis J. OO Univers	ess of Facility Collins Fun ity Blvd.,	eral Home W., Silve	Inc. er Spring	, MD 2	0901
			23a. Part 1. Enter the disease shock, or heart failure.	e, or complications that List only one cause on	caused the dea	th. Do not ent	er the mode of dy	ing, such as cardiac	or respiratory	arrest,		Interval Between
		å N	disease or condition	a	prob	abl	e my	(occurdi	al 10	referct	704	)
7			resulting in death)	Due to			- CI	torn	1:	010	٥	
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9	cuted nd ansit	min	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b> .								
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B.	death e attel	iciar	in the past 12 months?	4 Pre	gnant at time of			cy				
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s,	res tha signed be de	ğ		9		sulting in the u	nderlying cause gi	iven in Part I.				
Ö	requi	eted	719	VER WALL	100							
Rec	ne law has l ge 2 s	mple							auto	psy ormed?	prior to death?	completion of cause of
ā	in: Th		25 Was case referred to me	dical				26 Place of Dec	1 □ Yes	2 <b>ANO</b>	1 ☐ Yes	2 □ No
>	ysicia is cert direct		examiner?	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DOA Ot	hor:		0	other (Spe	cify)
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Sio	tendlr eath. or: A the fu	catic	2 ☐ Accident inv	restigation			M 1 [	]Yes 2 □ No				
Ξ	or Att	ıtil		torminad 20th Fla	ce of Injury - At I Iding, etc. <i>(Spe</i> c	nome, farm, str cify)	eet, factory, office			(Street and Nur wn, State)	mber or Ru	ural Route Number,
	spital			ifying Physician: To t								
	n 24 h	Medical		ical Examiner: On the								
	To the comp	Me	29b. Signature and title of ce	2 0		(	29c. Licer	nse number		29d. Date sign	ned (Mont	h, Day, Year)
	12+		HTG		Tan			0639	99	4-	- 14	1-09
(	5)		30. Name and address of per Ata Motamedi, M				Print) , Olney, M	20835 ע				
	Sta	ate	31. Date filed (Month, Day, )					- 20032				
	Registi		SFP 1	5 2009 2	Registrar's Sign	8. pa	Made					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2009 Month Sept **Physician** 7, 3:30P Nellie Myrtle Hayes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Temple Hills 6616 Napoli Road 5. Social Security Number 6 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year March 30, 7. Age (In yrs. last birthday) **Funeral** Days Min Year) 1 □ M 2 🖵 F 90 1919 Virginia 229 22 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 XXIo MD P.G. Temple Hills Director 10f. Zip Code 10g. Cltizen of What Country? 10e. Street and Number 20748 United States 6616 Napoli Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ∐Yes 2 XXXIII If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify. Specify: White 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Denfense Assembler permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiern Important: If Item 27 Is marked other this any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Jane Semones James Robert Crowder ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13556 51St. Lane North, Jupiter, Florida33478 Ralph Hayes (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sept 14. 2009 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Cemetery 21. Signatur / Funeral & 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old dice Licensee Alexandria Ferry Road, Clinton, MD 20735 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** 15AL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to fur as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed ohysician and the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🗷 No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy perform certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only o Other: 4 \( \subseteq \text{Nursing Home} \) 5 \( \subseteq \text{Residence} \) 2 No 6 Other (Spe 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Medical Certification: To this 27. Manner of Leath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif icense number

State Registrar 30. Name and a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 3:15 P M 2009 Dorothy Fisher Harrington Sept. 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 Rising Sun 107 Harrington Dr. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. Oct. 14, 1925 Director 220-22-0854 83 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Department of Health and Mental Hygiene important; if item 23a or 28a-f show important; if item 27 is marked other than "natural", or Items 23a or 28a-f show important; if item 27 is marked other than more in the motified and any injury or other traumatic event, item Medical Evantant count by motified and once. 1 X Yes 2 No Director Maryland Ceci1 Rising Sun 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21911 USA 107 Harrington Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M/No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 TXNo Specify ģ Specify: 3 

Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ John Allen Fisher Addie Lynch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mabel Harrington/Daughter-In-79 Old Zion Rd., North East, MD 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9-15-2009 Rising Sun, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Brookview Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one as a gon each line. such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Physician /Medical ue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offi-Examiner Due to (or as a consequence of): Physician/Medical ģ Completed Be Certification: To

Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, signed by the a this certificate has been si al director, page 2 should I or Attending F after death. After neral Director: A

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

28a-f show

•	<b>d</b>		*-190-		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 ☐ Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed?	
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	BR/Outpatient 3 □ D	OA Other: 4 \(\sum \) Nursing	Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death  Natural  Accident  The Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 ∐Yes 2 ∐No	28d. Describe how in	jury occurred
3 ☐ Suicide 6 ☐ Could not determine		ome, farm, street, factor	ry, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	Physician: To the best of my known aminer: On the basis of examinand manner stated.				e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier			oc. License number 554756		Date signed (Month, Day, Year) otem be/ 14 2009
30. Name and address of person wh	completed cause of death (Ite	23a) (Type, Print)	; Hwy St	203 Han	re de bray MD
31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature			•
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Registrar DHMH 17 Rev 1/2001

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Medical

		For State Registrar		State of Ma	aryland		artment of <i>rtificate of</i>			ental Hy	giene Reg. No.	200	Q	3101	Ω
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Exam		4a. Facility Name (If no	t institution, give	street and number)			4b. City, Town,	or Location	n of Death		4c.	County of De	eath		
		Casey Ho			o (In uro Io	not hirthday)	Rocks If Under 1 Year			8 Date of Ric	M M	ontgon		ce (State or Forei	an
Funera Directo		5. Social Security Numb	1 4-	M 2□F 7.A9	85	ast birthday) Yrs.	Months Days		s Min.	8. Date of Bir (Month, Da June 11	y, Year) 19:		Country	ersev	,,,
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the M 28a-f	Director	Maryland I	Montgom	ery		Damas	CUS 10f. Zip Code				10a. Citi:	zen of What	Countr	<u> </u>	
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death	Funeral	11. Marital Status	1441000	12. Was Decedent	Ever in U.S	S. 13. \	Was Decedent of f Yes, specify Cu		Origin? (Spe	ecify Yes or No	D-	14. Race - A Black, W	m <i>e</i> ricar		
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	by Fu	1 ☐ Never Married 3 ☐ Widowed 4 ☐		Armed Forces? 1	wwii		l □Yes 2X No			moun, oto.,		Specify:	Whi		
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t and thealth		Joan R. Ha		Wife	OOK DI	1071	7 Middle sition (Name of	boro		Dama	SCUS	Mary	lan	d 20872	
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parmit. Pages Department of Important: If if any Injury or or	aŭ.	4 Donaties 5 21. Signature of Funera		-	Met		itan Cre			9/13/0	9 A16	exandr	ia,	Virgini	a
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ie deat the att	Physician/M	in the past 12 mor 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)				l	Month		Day Year	
that the ed by detacl			nt conditions c	ontributing to death b	ut not resu	Ilting in the u	nderlying cause g	jiven in Pa	rt I.	23e. Did	tobacco u	se contribut	e to the	cause of death?	
w requires to been signed should be a	by by									1 🗆	Yes 2[	□No 3□	] Proba	bly 4 XUnknov	۷n
aw rec	Completed									24a. Was	s an	24b. Were	autop	sy findings availat pletion of cause o	le
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Physic rthis c	2	1 ☐ Yes 2 ☒ No 27. Manner of Death		Hospital: 1 ☐ Inpati		ER/Outpatier 28b. Time o	I 3 L DUA		1	me 5 Res 28d. Describe			Specify)	Hospice	
Attending r death. ector: Afte by the fune	tion	1 X Natural 5 2 ☐ Accident	i ☐ Pending investigation	(Month, Da	y, Year)	Injury	W	ork? □Yes 2		Edd. Deddillo	non injui	y occurred			
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 (Check only one)		ysician: To the best niner: On the basis of and manner st	of examinat										
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Funeral Director		5. Social Security N 218-48-5		5. Sex 1 □ M 2 🖾 F	7. Ag	e (In yrs. la	ast birthda. 62 Yrs.	y) If Unde Months		Hours	Min.	8. Date of Bi (Month, D May 23	rth ay, Year 1	947	Coui	place (State or Foreign ortry) yland
pu ,		Usual Residence of	f Decedent			100 City	, Town or	Location							1	I Od. Inside City Limits
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law rec as bee 2 shou	Completed	DIA	Butas									24a. Wa	opsy		Were aut	opsy findings available ompletion of cause of
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•		30. Name and add	iress of person v	vho completed ca	ause of a	death (Item	1 23a) (Typ	e, Print)				(BRO				
		ERIC /	HEMA.					DADI	10/-	- 0	6 (()	OME	11/	> 2	1 63	<i>e</i> .
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Menth **Physician** 2009 Pay Ruth Jones 8:30P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month. Day) 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min (Month, Day, Year 1/13/1930 1 □ M 2 🔀 F Director 79 577-06-8228 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location show "natural", or items 23a or 28a-f shovadical Examination to confide at 1 X Yes 2 □ No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8060 13th Street 20910 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 🗙 No Specify. ģ Specify 3 ☐ Widowed 4 ☐ Divorced Completed event, the Medical 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "rany injury or other traumatic event, Item Mad 2018. Elementary/Secondary (0-12) College (1-4or 5+) 12 Technician AT & T 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alpheus Jones Sarah Bell Harris 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George Jones / Brother 1314 8th Street, Boulder, Colorado 80302 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 9/16/2009 Silver Spring, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service. Inc. 21. Signature of Funeral Service Licensee no 7400 Georgia Avenue, NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Gequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed NOSTAGE and Due to (or as a consequence of) attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. 1 ☐Yes 2 ☐ No. 9 St Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page performed certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Certification: To After th funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled filled 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENBELT MARYL HOD 26770 25A HAMO ARKWAY 31. Date filed (Month, Day, Year) State 15

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔎 🧻 🥽 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 2056 M 2009 Medical Howard Lerov Johnson, Sr. 4a. Facility Name (if not institution, give street and number, **Examiner** 4c. County of Death Easy lemorial OSPITA If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months (Month, Day, Ye Country)
Maryland Director 218-16-9635 82 1926 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 207 North Fourth Street 21629 United States of America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. X Yes 2 No 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 HS Grad Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George W. Johnson Laura Murray Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Howard L. Johnson, Jr. Son 7188 American Corner Road, Denton, Maryland 21629 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🔼 Cremation 3 🗌 Removal from State Capitol Crematory 9/15/2009 4 Donation 5 Other (Specify) Dover, Delaware 21. Signature of Funeral Service Libered 22. Name and Address of Facility Moore Funeral Home, P.A. Thude 12 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Beath shock, or heart failure. List only one cause on each line, Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the bunal-tran that initiated events resulting in death) Last Due to (or consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No sate has been signed by the atte page 2 should be detached for 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural Natural 5 Pending after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier 🖹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

A631

State of Maryland / Department of Health and Mental Hygiene For State RegistrarAmend#23a.Prt.1.PerPhys.PGC9_Fortificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year September 6, 2009 **Physician** Alberta S. Johnson 1:30 p^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Ft. Washington 4204 Farmer Place 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 To 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 1 □ F Charlottesville Director 578-20-5604 88 9. 1920 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show traumatic event, the Mudical Examinar must be notified at Maryland Prince Georges 1√2 Yes 2 No Ft. Washington Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4204 Farmer Place 20744 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Specify: Black <u>ک</u> 3 ₩ Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Government Pages 1 and 2 should be filed verient of Health and Mental Hygient: If item 27 is marked other? 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Slaughter Harriett Biddle ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1147 W. 81st. Place Los Angeles, Ca. item 27 Haywood Johnson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or conce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill 9/18/2009 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Md. Mare and Address of Eacility Pope. P.A. 5538 Marlboro Pike/ Forestville, Md. e of Funeral Service Licensee 20747 23a. Pan 1. Einer the disease, or a implications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List inly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Renal Failure **Physician** disease or condition resulting in death) 1 /Medical Due to (or as a consequence of) **Examiner** Cardio Myopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and Due to (or as a consequence of) Box 68760. Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) P.O. 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1 □ Yes 2 🖾 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \Bursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Il Director: / 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 determined 4 Thomicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier 29c. License number 14666665 30. Name and docess of person who completed cause of death (Item 23a) (Type, Print) 9200 State

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DHMH 17 Rev 1/2001

Registrar

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		For State Registrar	State of Maryland			icate of l			Reg. No.	u û 9	31053
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Funeral Director		5. Social Security Number 6. S		st birtho	day) If	Under 1 Year onths Days	If Under 24 Hr Hours Min	n. 8. Date of Bi	rth ay, Year) /1921	Co	hplace (State or Foreign untry) Ston, PA
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ath with 23a or ust be	ralD	5805 QUEEN'S	CHAPEL ROAD			207				J. S.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates:			Decedent of H s, specify Cuba Yes 2 X No	ispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or Netro Rican, etc.)		4. Race - Ame Black, White Specify:	
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To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome pf pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death		opic pregnancy ner (s <i>pecify)</i>	1		2	3d. Date of de Month	livery Day Year
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r <b>Attendin</b> er death. <b>rector:</b> Aft by the fun	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e 290 Blace of injury. At hor	ne, farm		M 1□	Yes 2 No	28f. Location	(Street and	Number or R	ural Route Number,
Hospital o 4 hours aft Funeral Di ely filled in	ical Cer	29a. Certifier 1 Certifying P	hysician: To the best of my know miner: On the basis of examinati	vledge,	death oc	curred at the tir	me, date and pla	ace, and due to the	e cause(s)	and manner a	s stated. e to the cause(s)
To the I within 24 To the Complete	Medical	29b. Signature and title of certifier	and manner stated.			29c. Licens				signed (Moni	

State Registrar 31. Date filed (Month, Day, Year)
SEP 28 2009

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NURUL CHOWDHURY, MD; 15216 DINO DRIVE; BURTOWSVILLE, MD

20866
31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Year 1:20AM 2009 /Medical 4b. City, Town, or Location of Death (If not institution, give street and number) 4c. County of Death Examiner Medical Harford If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** 1 M 2 □ F Months Days Hours Min 407-62-159 Usual Residence of Decedent 62-1596 Director Hontuky filed within 72 hours after death with the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 No Harton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 21160 12. Was Decedent Ever in U.S. Armed Forces? 1 Dryes 2 □ No If Yes, Give Year or Dates:/964 — 65 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Modical Experiment once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No ð Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Be ( 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnan 2 Mriorie 19b. Mailing Address (Street and Number or Rural Route Number, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Jown, State 1 🗆 Burial 🌶 Cremation 3 Removal from State 5 ☐ Other (Specify) 4 Donation Robei 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Failure 71 day disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 71 dery Hypotension Sequentially list conditions, if a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last day Brain Ceence Due to (or as a consequence of) attending physician for use as the burial day Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an has After this certificate perform Division of Vital 2 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15angskig Kamal M.D. D0065641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ð BANGORIA, M.D. 500 Upper Chesapeake Drive Bel Air, MD 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 28 2009

M80051558

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Vear FLITENBER 18.200 1.40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BOOTMORE NARHINGTON MEDICAL CILEN BURNIE der 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🗹 F Director - U Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Exprinter must be notified at Director 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygi em 27 is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental 2 TRAI injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 8513 MAIN HUE IASADENA, MD. ZIIZZ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 9-16-09 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility 260 (MOUNTAIN RT , MARYLAND 21122 Part Endr he e, or complications and each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) c this 1 ☐ Yes 2 **N**o 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 124 hours after death.

12 hours after death.

13 Funeral Director: A pletely filled in by the filled 1 □Yes 2 Accident 2 □ No Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🔽 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Sign are and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1560 ne and address of person who completed cause of death (Item 23a) (Type, Print) nosphal 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Completed by Funeral Director

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Physician/Medical

Medical Certification: To Be Completed by

For State Registrar				Ce	rtifica	te of	Death		Reg. N	lo. / /	LIC	3105
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Street and Nur. 1337 Ly	^{nber} dia Stre	eet			10f. Z	ip Code 2181	.3		-	Citizen of U.S.A	What Cour	ntry?
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iane Ki	Ltchens	(Daughte	er)	1133	7 Ly	dia S	Street	Bi	shopville	, MD	218	13
. Method of Dis	•	Пр · ·	20b. P	lace of Dispo emetery, cre	osition (Namatory or	ame of other place	ce)	Da	ate 20c.	Location	- City or To	own, State
	☑Cremation 3 5☐Other (Spec	☐ Removal from S cify)	state i	matory				9-10-	-2009 De	1mar	, Del	aware
Signature of Fu	uneral Service Lic	ensee*	_	S	2. Name :	and Addre Fune	ess of Facility eral H rove S	lome		r, Di	E 19	940
la. Part 1. Enter t	he isease, or co	mp) ations hat ca	used the deatl						r respiratory arrest,			Approximate Interval Between
mediate Cause	(Final	y File Sause on ea	VANC	en.	Dr	ME	NTIA	_				Onset and Death
ease or condition sulting in death)	ori 🥒	a. Due to (	or as a consequ	uence of):	100	= 41   1	V 117					
		5 de 10 (I										
quentially list co	nmediate	b. — Due to (	or as a consequ	uence of):								
use. Enter Unde use (Disease or	erlying injury		,									
t initiated events ulting in death)	Last	C Due to (	or as a conseq	uence of):								
		d	·									
		d								т		
FEMALE: b. Was deceden in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?		irth 2 🗖 Feta ant at time of c	Ideath 3[	□ Ectopic □ Other (	c pregnanc (specify) _	Э			1	ate of deliv lonth	very Day Year
		contributing to de	ath but not reco	ulting in the	nderlying	Cause di	en in Part I		23e, Did tohace	to use con	tribute to t	the cause of death?
Julei sigili		. John During to de	Sat HOLIESI	9 11 1110 1	yiiik	, yn			1 ☐ Yes			bably 4 Unknow
									24a. Was an autopsy performed		prior to co death?	opsy findings available ompletion of cause of
Was case refer	red to medical						06 DI-	of Darit		NQ	1 □Yes	2 <b>2</b> No
was case refer examiner?	/	Hospital:				Oth	2011		(Check only one)			
	M/O	Hospital.	anotinut of	ED/O	nt all	004 100	THE PERSON NAMED IN	real- **	mo E		hor in	(6.)
1 Yes 2 ≥		28a. Date	npatient 2   of Injury	ER/Outpatie		28c. Inju	4 271		me 5 Residence			ify)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician** /Medical **Examiner** 

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2 Accident

4 Homicide

3 Suicide

29a. Certifier (Check only one)

MD

6 ☐ Could not be

SEP 11

determined

29c. License number 00062172

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1604 MARKET ST POCOMOKE CITY MD 21851 SATYAL, MD SHARAD

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#30perDVR G895 9/28/09 WS 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Zear 2334 LONG **GEORGE** LE ROY September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Easton talbot Memorial If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year)

JG • 31 , 1940 WASHINGTON, DC 1 🛛 M 2 🗆 F Months Days Hours Yrs. Director 578-54-9487 AUG. Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No DENTON MD CAROLINE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U. S. A. 25644 GAREY ROAD 21629 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 58 – '61 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. 12 FACILITIES MECHANIC POST OFFICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GEORGE WELLINGTON LONG FRANCES EDNA DEMENT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Seorge HILDA G. LONG/WIFE 25644 GAREY ROAD DENTON, MARYLAND 21629 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) SEPTEMBER 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 23,2009 CHELTENHAM, MD MD VETS.CEMETERY Donation 5 Other (Specify) 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 21. Signature of Funeral Service Licensee four Bast M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Luna Cancer disease or condition resulting in death) Medical Due to (or as a nsequence of) Examiner COPD Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): well moura physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 🗌 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) work? 1 🗌 Yes 2 🗌 No injury 5 Pending death. 2 Accident
3 Suicide neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) De099487 Mubotsu 9-18-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 Shore Hospitalists Assoc. EMH 219 S. Washington St. Easton, Md. 21601 John Botsis 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

			State of Maryland / Dep  1 - State Registrar Ce	eartment of Health and N ertificate of Death		ene . No. C 0 0 9	31053		
ı			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death		
	Physicia /Medic		ALAN VERDIE LEHMAN		SEPT.	18 2009	7:15A M		
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
			13740 CHARLES STREET  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday	CHARLOTTE HALI  (i) If Under 1 Year   If Under 24 Hrs.		CHARLES			
	Funeral Director		175-22-0959	Months Days Hours Min.	8. Date of Birth (Month, Day, You SEP . 10,	1928 PEN	nplace (State or Foreign untry) NNSYLVANIA		
	and ww		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits		
	Maryl -f sho	tor	MD CHARLES CHARLOT	TE HALL			1 ☐ Yes 2 🔀 No		
	h the	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?			
	23a c	ral	13740 CHARLES STREET	20622		U. S. A	<i>A</i> .		
36	be filed within 72 hours after death with the Maryland hal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Evanirar must be notified a	by Funeral	1 ☐ Never Married 3 ☐ Married 1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 □ Yes   XXXIII Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: TATE			
21215-0036	hours atural		15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	b. Kind of Business/			
212	filed within 72 Hygiene. other than "nai ent, the Medic	Completed	(Specify only highest grade completed)   (Giv	e kind of work done during most of work DO NOT use retired)	ring		•		
	ed wit	Con	2 CIV	IL ENGINEER	<del></del>	J.S. AIR	FORCE		
Maryland	should be filed nd Mental Hygi marked other matic event, I	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma				
Š	is 1 and 2 should by Health and Menitem 27 is marke other traumatic	မ	HARRY LEHMAN  19a. Informant's Name/Relationship (Type. Print)  19b. Mai	Ing Address (Street and Number or Rui	YN LEPLE				
	1 and 2 s Health ar em 27 is			40 CHARLES ST.,					
ze,	es 1 al of Hec litem rothe		20a. Method of Disposition 20b. Place of Disposition			c. Location - City or			
Ĕ	Pages ment of ant; If its ury or o			S.CEMETERY 24,		CHELTENHA	AM, MARYLAN		
Baltimore,	permit. Pages Department of Important; If it any injury or o			22. Name and Address of Facility RANGES WASHINGTON					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	t,	Approximate Interval Between		
	Physician	ier	Immediate Cause (Final disease or condition resulting in death)	heart failure			Onset and Death		
	/Medical Examiner		Due to (or as a consequence of):	heart far live					
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1927 000	1				
r	cuted nd ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c						
Ö,	e exe sian ar urial-t	EX	that initiated events c						
8/60,	icate be executed physician and the burial-transit	dical	d	4					
Box 6	death certifi e attending id for use as	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	ivery		
j	w requires that the death certifi s been signed by the attending should be detached for use as	Physician/Me	in the nest 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year		
ຂຸ ກໍ	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did toba	cco use contribute to	the cause of death?		
ğ	equire		Chronic obstructive lung	disease	1 ☐ Yes	2 No 3 P	obably 4 Unknown		
Vital Records,	lawr hasbe	Completed			24a. Was an autopsy	prior to	topsy findings available completion of cause of		
<u>e</u>	r: The icate h	Cou			performe 1 □ Yes 2/1	death? No 1 ☐ Yes	2 □No		
<b>\</b>	sician: The law certificate has t irector, page 2 s'	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 (ANo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Other	th (Check only one)	. Dou			
0	g Phy er this eral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how	ce 6 Other (Spe injury occurred	city)		
S S	ath. rr; Aft	atio	1 Natural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation	M 1 ☐ Yes 2 ☐ No					
DIVISION OF	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, is	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ro State)	ıral Route Number,		
_	spital ours a neral [		29a. Certifier 1 Certifying Physic in To the best of my knowledge, dea	ath occurred at the time, date and place	and due to the cau	use(s) and manner a	s stated.		
	ie Hos 124 h ie Fur	Medical	(Check only one) 2 dical Examiny : In the basis of examination and/or one)	investigation, in my opinion, death occu	rred at the time, date	e and place, and due	to the cause(s)		
	To th Within To th Comp	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Mont			
			17 4	WD33471	Q C	3-18-	07		
	7+1		30. Name and address of person who completed cause of death (Item 23a) (Type B. LARRY JENKINS, M.D. 111 L.	AGRANGE AVE. LA	РЬАТА -	MD 2064	5		
ı	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature.	J					
	Registr	ar	SEP 28 2009 Rement B. Jane						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Patrick Mathews Long State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day Y September 11, 2009 Medical Examiner Patrick Mathews Long 2250 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Doctors Hospital** Lanharr Prince George's 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) 215-74-1819 Months Days Director Hours 06/23/1962 Country) PA 1XXM 2 F 47 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince Georges College Park Yes 2XX No 28a-f show , or items 23a or 28a-f shor r must be notified at once. death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 USA 9712 53rd Avenue Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces' White, etc. Never Married 2 Married Yes 2XX No permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygens I be to I limportant: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examiner. White 4 X Divorced 3 Widowed If Yes, Give Year Yes 2 X No specify: Specify. ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Project Manager Graphic Design 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Joan Mathews Be Herman Clyde Long, Jr. 19a. Informant's Name/Relationship (Type, Print) Clyde Long, brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Harper Ct. Lafayette, CA 94549 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 9/14/2009 Beltsville, MD Chesapeake Crematory Donation 5 Other Specify 21. Signature of Funeral Sea M0153922. Name and Address of Facility & Cremation Svcs. 933 Gist Ave. Silver 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical the attending physician ed for use as the burial -UNPENDED AMENDED Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Year Month Day past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown a Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed be ģ Records, P. 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? certificate l' rector, page ✔ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital æ examiner? lospital: 1 Other₄ Inpatient 2 V ER/Outpatient 3 this DOA Nursing Home 5 Residence 6 1 V Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: n 24 hours and he Funeral Director: A 1 V Natural Pending Yes 2 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 cal Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 12, 2009 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar 31. Date filed (Month

Registrar's Slo

			1 - State of Maryland / De State of Maryland / De Registrar	epartment of l Certificate of		, ,	iene eg. No. (_ U	35	31060
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Timothy McFarland			2. Date of Deat Month	Day	Year	3. Time of Death 23/0 M
	Examin		4a. Facility Name (II not institution, give street and number)	4b. City, Town, o	r Location of Death		4c. County o		
4	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months   Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 7,			ace (State or Foreign try) PA
	be filed within 72 hours after death with the Maryland ntal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Madical Evers necessary to a natified at	Funeral Director	1 ☐ Never Married 2 ⚠ Married   1 ♠ Yes 2 ☐ No	10f. Zip Code 17268 13. Was Decedent of N If Yes, specify Cub		1	14. Race Black	hat Count SA - America	an Indian, tc.
פר	be filed within 72 hours after al Hygiene. 1 other than "natural", or Ite svent, the "coted Exercita	Be Completed by	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  1 2 Adm  17. Father's Name (First, Middle, Last)	1 □Yes 2ÅNo ecedent's Usual Occup Give kind of work done fe. DO NOT use retire inistrator	pation during most of work d) 18. Mother's Nam	e (First, Middle, I	16b. Kind of Bus Persona Maiden Surname	.1 Ca:	
Z	2 should be f and Mental I is marked of aumatic eve	은	Abner Kenneth McFarland	failing Address (Cares		e Lucill			Code)
Z Z	nd 2 shalth an alth an 27 is r			lailing Address <i>(Street</i> 98 Green R					
aitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic esonce.		4 Donation 5 Dothar (Specify) Cumber 1	isposition (Name of crematory or other pla and Valley			20c. Location - 0	•	
Dail	permit. Departri Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Addre		neral Ho	ome, Inc		
	Cotte be executed // Medical Examiner the burial-transit	dical Examiner	23a. Parl . Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of).  Due to (or as a consequence of).	Pulmona			<del>6</del> 51,		Approximate Interval Between Onset and Death
P.O. BOX 687	Io the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  Within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnant 5 ☐ Other (specify) _	су		23d. Date Mor	e of delive	ry Day Year
- SD	signed		Part II. Other significant conditions contributing to death but not resulting in the Respiratory failure	ie underlying cause giv	ven in Part I.	23e. Did tol			e cause of death?
al Records,	n: The law requicate has been ry page 2 should	Completed by				24a. Was a	n 24b. W	/ere autoprior to coneath?	osy findings available npletion of cause of
. VItai	ysıcıar is certil directo	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: ☐ This patient 2 ☐ ER/Outp.	atient 3 DOA Oth	26. Place of Deat ner: 4 ☐ Nursing Ho	th <i>(Check only on</i> ome 5 ☐ Reside		er (Specify	· · · · · · · · · · · · · · · · · · ·
VISION OF	on the hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Certification: T	27. Manner of Death  1	iry Woi M 1 □	ry at	28d. Describe ho	ow injury occurre	ed	
2	pital or A ours after eral Direc filled in by		4 ☐ Homicide determined building, etc. (Specify)  29a. Certiffier 1 ♣ Certifying Physician: To the best of my knowledge, c		enclo bas atta	28f. Location (Si City or Town	n, State)		
:	he Hos in 24 hr he Fun pletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/one) and manner stated.						
	Vith Com	Σ	29b. Signature and title of certifier RESIDENT	29c. Licen:		2	9d. Date signed	1	
•	.6		30. Name and address of person who completed cause of death (Item 23a) (Ty	rpe, Print)	P2305		04	101-	.009
	12		BENADETTE MAKORY 72 500  31. Date filed (Month, Day, Year)  32. Registrar's Signature	the Green	est. B	altimose	MD	2120	2
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 2 8 2009	Kal					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Leland Carl Malone 0453 /Medical September 20, 2009 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany

9. Birthplace (State or Foreign Cumberland Memorial Hospital
5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Sep 23, 1921 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Country) Months Days Hours Min. 1 M 2 □ F 219-03-9927 Director 87 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ital Madical Examination unit to notified at any Injury or other traumatic event, Ital Madical Examination 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location WV Mineral Wiley Ford Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26767 Rt. 1 Box 78 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify: Specify: WWII 3 X Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Iron Workers Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Alkire Malone John Malone ည Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 219 Wiley Ford WV 26767 19a. Informant's Name/Relationship (Type. Print) John Malone son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Fort Ashby Cemetery 9/24/2009 WV Fort Ashby 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility at Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part f. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lisyonly one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0033280 September 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

GUPTA, M.D

28 2009

31. Date filed (Month, Day, Year)

32. Registrar's Gignatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 6 Monag 11.20 September 12,2009 /Medical 4a. Facility Name (If not institution, give street and number)
Baltimore Washington Medi 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie, MD. Conter 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours 214-66-1015 **Director** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director SLEN BURNIE 1 ☐ Yes 2 ☑ No MD. ANNE ARUNDO 10e. Street and Number 10g. Citizen of What Country? ò 102 CRAIN HWY NORTH Funeral "natural", or items 23a U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify þ Specify: WhITE 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than College (1-4or 5+) KESIDENTIAL PL permit. Pages 1 and 2 should be file.
Department of Health and Mental Limportant: If them 27 Is many injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SR. RALD E. MONAGHAN STRATTON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD. 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) ODENTON 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility 2601 MOUNTAIN RD. HASADENA, MD. 21122 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** sen disease or condition resulting in death) Medical Due to (or a a con i quence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to ( ) as a consequence of) burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 XNo certificate 1 □ Yes 1 ☐ Yes 2 No director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA After this the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 🔲 No 3 Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide

The law requires that the death certificate be execute P.O. Box 68760, of Vital Records, Hospital or Attending Physiclan: Division hin 24 hours after death. within To the

Baltimore, Maryland 21215-0036

29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 305 dhish Kan Hospital

DV. Glen Brownie, MD. 21061

31. Date filed (Month, Day, Year) SEP 28 2009 Registrar

32. Registrar's Signature

			Please 7	Type or Print i State of Mary								-	
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			1. Decedent's Name (First, Middle, Last			_				2. Date of D		ay Yea	3. Time of Death
	Physici /Medio		Ernest E. Marx							Sept	11,		7:00 A ^M
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	and		10a. State 10b. County	10	c. City, Tov	vn or Lo	cation						10d. Inside City Limits
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	should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural" or liems 23a or 28a-f show marked other than "natural" or liems 23a or 28a-f show marke event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S.	13. V	Vas Decedent	of Hispar	nic Origin? (	Specify Yes or Note to Rican, etc.)	10-		nerican Indian,
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o j	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown	ne of death	5 L	Other (specil	ý)					,
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:	ie Ho 124 t ie Ful	Medical	(Check only 2☐ Medical Exam one)	Iner: On the basis of ex and manner stated		and/or in	vestigation, in	my opinio	on, death oc	curred at the tim	ie, date a	and place, and o	due to the cause(s)
3	To the mo		29b. Signature and title of certifier		Λ			cense nui				-	onth, Day, Year)
	1000	1	1 Thomas	5	0_		DC	MD 1	2568		9	9/11/200	09
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#### State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician
/Medical
Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it e Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed and the attending physician been signed by After death. within 24 hours after deat To the Funeral Director:

Division of Vital Records, P.O. Box 68760,

completely filled in by the funeral director, page 2 should be detached for

	1 - State Registrar				Ce	rtificate of	Death		Reg. N	.2 U	09	3106	l.ş
	1. Decedent's Name	(First, Middle	e, Last)					2. Date of D	Death Da	av.	Year	3. Time of Death	
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er	4a. Facility Name (If	not institution	n, give street and nu	ımber)		4b. City, Town, o	or Location of D				of Death		
	4165 MARB	URY FR	EELAND PL	ACE		INDIAN	HEAD		(	CHARI	ES		
	5. Social Security Nu		6. Sex 1 <b>X</b> □ M 2 □ F	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of E	Birth Da <i>y, Year</i>	-)	9. Birthp Coun	lace (State or Foreig	gn
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ĭ	19a. Informant's Na		10h Maili	MAUDE E. BLAIR MARSHALL    Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						0-4-1			
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20a. Method of Disposition 20b. Place of Disposition (Name of								Date			City or To		_
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Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 2 Accident

5 ☐ Pending investigation 6 Could not be determined

1 Inpatient 28a. Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

D0026064

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IDYASAGAR AN MANGANDLA

Hospital:

583-THEODORE

State Registrar

Medical Certification: To

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Og **Physician** 7:38 AM 2009 A. Mitchell Barbara /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico at th HOSPI 8. Date of Birth
(Month, Day Year)
2/21/1943 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. Months 1 ☐ M 2**X** F Maryland 214-42-7630 66 **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment in unified at 10b. County 1 XYes 2 □ No Director Salisbury Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21804 by Funeral 706 E. Lincoln Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2**K** No Specify Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Cable TV Company Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sally Martin Clyde Martin ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 706 E. Lincoln Ave. Salisbury, Maryland 21804 Fred Mitchell/husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, Maryland 9/10/2009 Salisbury Crematory 21. Signature of Funeral Service Lice HOLLOWAY Funeral Home P.A. 501 Snow Hill Rd. Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): ZNCRPHALOPATHY **Examiner** 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 1 □Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed' 2 0 No 1 ☐ Yes certificate 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: Other (Specify) 2 1 NO 4 ☐ Nursing Home 5 ☐ Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Certification: To this s after death.

I Director: After this of in by the funeral d 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day, Year) Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide า 24 hours aft ie Funeral Di detely filled ir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or in rection in the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the prope Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cortiller 005 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

Registrar's Signatur

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year Paoletti Luigi 20, 2009 10:45A /Medical September 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland
If Under 1 Year | If Under 24 Hrs Allegany Memorial Hospital
5. Social Security Number 6. Date of Birth 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** ^{Year)}917 Months Days Hours Min. 1 M 2 □ F Feb 10. 166-09-2399 92 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and once. MD Allegany Cumberland **Funeral Director** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 730 Furnace Street 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Be Completed by If Yes, Give Year or Dates: Specify. WWII Specify: 3 Nidowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) machinist Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guiseppe Paoletti Maria Marrone ပ 19a. Informant's Name/Relationship (Type. Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3325 SE Summer Place Port Orchard WA 98366 Ann Paoletti daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State SS Peter and Paul Cemetery 9/26/2009 MD Cumberland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Addressi of Facility al Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. 11. Enter the district, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of yone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END **Physician** STAGE AL 2N2_ /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed as the burlal-tran Due to (or as a consequence of) Jivision of Vital Records, P.O. Box 68760, To the Funeral Director After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after dea 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 2009 30. Name and address of person who complet of cause of death (Item 23a) (Type, Frint BARRERA SOO KOBUSTIANO M.D

Registrar

State

31. Date filed (Month, Day, Year)

SEP 28 2009

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygie Certificate of Death

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ene . No.	6	U	2	3	1	U	3,

2. Date of Death

3. Time of Death

Physic /Med Exam

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be retified at once.

Baltimore, Maryland 21215-0036

Physician /Medica **Examine** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

ian ical	Margaret D.	Pampley				Septe	mber 1	10, 200	9 8	10:35 p	) М		
ner	4a. Facility Name (If not institution	on, give street and number)		4b. City, Tov	n, or Location o	f Death		4c. County	of Death				
	Crofton Care & R			Crof				Anne A					
i r	5. Social Security Number 579–20–6787	6. Sex 7. Ag	je ( <i>In yr</i> s. last birthd <b>86</b> Yrs	Months D	ear If Under 2 ays Hours	Min. 8. Date (Mon. Apri	of Birth h, Day, Ye 20,	1923	9. Birthplace (State or Foreign Country) Washington, DC				
	Usual Residence of Decedent		140-03-7										
7	10a. State 10b. County  Maryland Anne		10c. City, Town o						1	0d. Inside Cit 1 ☐ Yes			
ecto		Arundel	Crofta								2 <del>[-</del> ] NO		
al Dire	1723 Truro Roa	đ		10f. Zip Co 211			10g.	Citizen of W	/hat Coun SA	itry?			
Funeral Director	11. Marital Status  1 □ Never Married 2 □ Ma	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐	Ever in U.S.	13. Was Deceden If Yes, specify	of Hispanic Orig Cuban, Mexican	gin? (Specify Yes , Puerto Rican, etc	or No-		e - Americ k, White, e	ean Indian, etc.			
ed by	3 Widowed 4 □ Divorce	d Year or Dates:		1 □Yes 2 <b>X</b> ecedent's Usual C			16h	Specify:	MILL				
olet	(Specify only high	nt's Education est grade completed)	(	Give kind of work of fe. DO NOT use t	one during most	of working	100	. Kind of Bu	SHESS/INC	Justry			
Completed	Elementary/Secondary (0-12)	College (1-4or !	5±)	nistrative	Assistant			Federal		ærnment			
To Be	17. Father's Name (First, Middle Percy Adwin Dav				1	r's Name <i>(First, M</i> rgaret J.			e)	•)			
-	19a. Informant's Name/Relation	ship (Type. Print)	19b. M	lailing Address (S	reet and Numbe	er or Rural Route I	lumber, Ci	ty or Town,	State, Zip	Code)			
	Robert E. Harring	gtan/Nephew	17	723 Truro	Road, Cro	ofton, Mary	land 2	21114					
	20a. Method of Disposition	a □ a 14 a a	20b. Place of D	isposition (Name crematory or othe	of place)	Date	Į.	. Location -	City or To	wn, State			
	1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (	3 Li Hemoval from State Specify)	Parklawn	Memorial 1	Park	September 2009		ockvil1	le, Ma	ryland			
	21. Signature of Funeral Service	Licensee		22. Name and A	ddress of Facility	Funeral Ho	me Inc	! <b>.</b>					
	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 2090  23a. Part I. Letter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												
	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	a consequence of):	Fram	Ma.	cardiac or respirat	ory arrest,		-	Approximate Interval Betwood Conset and D	ween		
cal Examiner	Sequentially list conditions, large leading to minimizate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Of or as a consequence of):  c. Due to (or as a consequence of):												
hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal death	3 ☐ Ectopic preg 5 ☐ Other (speci		_	23d. Date of delivery Month Day Year						
d by P	Part II. Other significant condit	ions contributing to death b	out not resulting in th	ulting in the underlying cause given in Part I. 23e. Did to 1 ☐ Y					obacco use contribute to the cause of death?  Yes 2 ™No 3 □ Probably 4 □ Unknown				
Completed						24a.	Was an autopsy	l p	rior to co	psy findings a	available ause of		
ပ္ပြဲ						1 🗆 '	performed Yes 2 🔀		leath? □Yes	2 <b>X</b> No			
Be	25. Was case referred to medica examiner?					of Death (Check	only one)						
	1 Yes 2 No	Hospital: 1 ☐ Inpati	<del></del>	atient 3 DOA		rsing Home 5	Residence	idence 6 ☐Other (Specify)					
ation:	27. Manner of Death 1 Manual 5 ☐ Pendi 2 ☐ Accident invest	28a. Date of Inju ng (Month, De ligation		ne of 28c.	Injury at Work? 1 □ Yes 2 □ I		cribe how in	njury occurre	ed				
Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deteri	minod   Zoe. Flace of In	ury - At home, farm c. (Specify)	me, farm, street, factory, office 28f. Location City or To				(Street and Number or Rural Route Number, rown, State)					
edical (	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the best I Examiner: On the basis of and manner st	of examination and/	death occurred at or investigation, in	he time, date an my opinion, dea	nd place, and due the occurred at the	to the caus time, date	e(s) and ma and place, a	nner as s and due to	stated. the cause(s	)		
Me	29b. Signature and title of pentil	er .		29c. License number  29c. Script				29d. Date signed (Month, Day, Year)					
	30. Name and address of person	who completed cause of c	death (Item 23a) (Ty	rpe, Print)	inhiere	Sw	Char	A.	mi	MAI	11061		

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Anna Lillian Reece September 17, 2009 2:15 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Ravenwood Lutheran Village Hagerstown
Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 18, 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) . 191<u>8</u> Funeral Days Hours Months 1 ☐ M 2 K F Oct. Maryland 90 216-14-6352 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 X Yes 2 ☐ No Director Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code U.S.A. 1183 Luther Drive 21740 Funeral 14. Race - American Indian, Black, White, etc. th and Mental Hygiene.
7 is marked other than "natural", or items traumatic event, I'm Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛛 No Specify: Specify: 2 3 Nidowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John L. Biser Minnie Mae Knight ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 36 Crystal Falls Dr., Smithsburg, MD Michael A. Reece/Son Department of Health Important: If Item 27 any Injury or other tronce. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 9/21/2009 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery Hagerstown, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licens 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Mouth neumonic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner Diss to for as a consequence of dram, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day In the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: autopsy 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl. one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier within 24 ho To the Fune completely f and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed caus of death (Item 23a) (Type, Print) 1 Street Hagerstown MD 2740. 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 11, 1. Decedent's Name (First, Middle, Last) Morton ROSENFELD **Physician** 2009 3:15 P September /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville 1801 E. Jefferson Street #305 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 28 Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours 1 X M 2 □ F 1914 Aug. 95 Director 181-10-8944 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experies must be rediffed at 1 X Yes 2 □ No Rockville Director Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 1801 E. Jefferson Street, #305 United States Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ∐Yes 2 ∭XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. ð 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pharmacy 4 <u>Pharmacist</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Celia Wolf Samuel Rosenfeld ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 st of Health ar fitem 27 lt 1129 Pipestem Place, Rockville, MD 20854 Beverly Greenfeig, Daughter permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Roosevelt Park Cemetery 09/14/09 Trevose, PA 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundamental and the second Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ٥ **Physician** resulting in death) /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ner Exami trar and burial-t Due to (or as a consequence of): Box 68760 physician certificate be Physician/Medical the signed by the attending I IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) P.0. □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown been si should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy 2 No certificate 1∐Yes 2**X**∏No 1 ☐ Yes Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier 09/11/09 D 0060129 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brent K. Cole, M.D., 5530 Wisconsin Ave., Chevy Chase, MD

State Registrar 15 15 2009



20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 09 Month 10 Day 2009 1:10A M David Brown Robinson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Voor Months Hours Min. 1 X M 2 □ F 83 Director 071-20-5471 11/22/1925 DC Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho 1⊠Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 15115 Interlachen Drive, Apt. 1020 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 Married □Yes 2 TXNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2 🔀 No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, IT M. Elementary/Secondary (0-12) College (1-4or 5+) 12 Dir. Employee Labor Relations US Postal Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle Brown ပ Sydney Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15115 Interlachen Drive, Silver Spring, MD 20906 Marilyn Robinson / Wife 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD 09/18/2009 21. Sign re of Funeral Service License 22. Name and Address of Facility MCGuire Funeral Service,  $\kappa n$ 7400 Georgia Avenue, NW, Washingotn, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner unen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine certificate be executed the burial-transi conal nding physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atter 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 🔀 Unknown 1 Yes 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has N autopsy performed page this certificate 2 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 ☐ Yes Certification: To 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 □Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

7600 Carroll Avenue, Takoma Park Maryland 20912 31. Date filed (Month, Day, Year) 15 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Padma Chirumamilla,MD

3

D6383

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 27 per phys. G896 10/9/09 dk State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 6. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Eugene F. Rutzler III 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** VICOMIC TENINSULA REGIONAL SALISBUR MEDICAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 141-22-6182 1**⊠** M 2□ F Director 09/19/1931 New Jersey Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It is Medical Examinations to a collection of the content and the collections. 1 ☐ Yes 2 X No Director Maryland Worcester Newark 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21841 USA 6705 Five Mile Branch Road Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: AirForce 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify þ Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) pipefitting pipefitter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Lee Eugene F. Rutzler မ 19a. Informant's Name/Relationship (Type. Print)
Eugene F. Rutzler V/son 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34621 Moskoe Court, Pittsville, MD 21850 permit. Pages 1 and 1 Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/11/09 East Hanover, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livens 22. Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Kette 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** . 5 Adenocarcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): P.O. Box 68760, physiciar Physician/Medical the attending phed for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No After this certificate has been signed by the funeral director, page 2 should be detached 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 XNo 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 X Natural ours after death.
neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier .M. ) 130690 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 100 E. Carroll St. Solisbury MD. MARTIN M. O. 31. Date filed (Month Day, Year) 32. Registrar's Signatur State 2009

Registrar

16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State of Marylan		rtment of He tificate of D			jiene _{Reg. No.} 200	9 31073
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Yea	
	/Medic	al	Bety 1. Shriver		4b. City, Town, or I	ocation of Dea	Sept.	13 200 4c. County of De	
	Examin	er	4a. Facility Name (If not institution, give street and number)  Montgomery General Hospital		Olney		****		gomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr		n 9. B	Birthplace (State or Foreign Country)
	Director		577-26-5193 1 M 2 S F 93	Yrs.	Months Days	Hours Mi	Sept.	12, 1916 E	Pennsylvania
ľ	2		Usual Residence of Decedent  10a. State 10b. County 10c. Ci	ty, Town or Lo	eation				10d. Inside City Limits
	shov	2							1 □Yes 2 🛣No
	28a-f	Director	Maryland Montgomery  10e. Street and Number	Silver	Spring 10f. Zip Code			10g. Citizen of What	Country?
3	Sa or		1505 Dale Drive		20910			USA	
	ms 22	Funeral	11 Marital Status 12. Was Decedent Ever in U	J.S. 13. \	Was Decedent of His	spanic Origin?	(Specify Yes or No-	14. Race - Ai Black, Wh	merican Indian,
30	rs aner or ", or iter	by Fur	Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☑ No  If Yes, Give  Year or Dates:		f Yes, specify Cubar 1 □Yes 2🏞 No	Specify:	erto Alcan, etc.)	Specify: Wh	
9500-61212	atura		15. Decedent's Education	16a. Deced	dent's Usual Occupa	ition	and in a	16b. Kind of Busines	ss/Industry
2 2	Media	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	life. l	kind of work done d OO NOT use retired)	uring most of w	rorking	Our Hor	m.o.
7	giene giene	Ö	12	нс	memaker			Own Hor	e
land	z should be liled within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, it a Wedical Exercited must be redified at	To Be (	17. Father's Name (First, Middle, Last) Charles Omar Tracey				ame (First, Middle, Key Boye		
Mary	nd 2 shoualth and 1		19a. Informant's Name/Relationship (Type. Print) Kay Griffith/Daughter	19b. Mailir	ng Address <i>(Street a</i> 149 He <b>ri</b> t	nd Number or cage Hi	Rural Route Number	er, City or Town, State , Brookev:	e, Zip Code) ille, MD 20833
Baltimore, Maryland	permit. Pages 1 and 2 should be lited within 72 hours after death with the warylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, its Medical Examination and once.  Once.		₩ Rurial 2 Cremation 3 Removal from State	cemetery, crer	sition (Name of matory or other place Cemetery	Se	Date pt. 16 2009	20c. Location - City Waynesbot	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	22	Name and Address Francis J. 500 Univer	s of Facility Collingsity B	ns Funera lvd. W.,	1 Home Inc	ring, MD 20901
1	Physician /Medical Examiner bhysician and bhysician and street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street street st	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consection of the condition of the cause) and the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause	quence of):	-ymphor	ei .			Approximate Interval Between Onset and Death
O. Box 68	eath certi attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ to 9 □ Unknown  23c. If yes, outcome of pregion in the past 12 months? 4 □ Pregnant at time of 9 □ Unknown	tal death 3	☐ Ectopic pregnance	y		23d. Date of Month	delivery Day Year
ds, P.	w requires that the debeen signed by the should be detached	2	Part II. Other significant conditions contributing to death but not re	esulting in the u	inderlying cause give	en in Part I.	23e. Did		e to the cause of death?  Probably 4 ☐ Unknown
Division of Vital Records,	aw as t	Completed					24a. Was — auto perfo 1 □Yes	psy prior ormed? deat	e autopsy findings available to completion of cause of h? Yes 2 🗷 No
ta	an: ] rtifica tor, p	Be C	25. Was case referred to medical	_		26. Place of I	Death (Check only		
>	Physician: this certific ral director,		examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 [	☐ ER/Outpatie	nt 3 □ DOA Oth	er: 4 🗆 Nursin	g Home 5 ☐ Res	idence 6 Other (	Specify)
0	ng Ph fter th neral	٦	27. Manner of Death  ↑ Natural 5 ☐ Pending  28a. Date of Injury (Month, Day, Year)	28b. Time o	Worl	y at </td <td>28d. Describe</td> <td>how injury occurred</td> <td></td>	28d. Describe	how injury occurred	
<u> </u>	Attending r death. ector: After by the fune	atic	2 Accident Investigation			Yes 2 □ No			D. I.B. A. Museban
DIVIS	al or Attend s after death Il Director:	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spec	home, farm, st c <i>ify)</i>	reet, factory, office			(Street and Number o wn, State)	r Rural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, dea nation and/or i	th occurred at the ti nvestigation, in my o	me, date and popinion, death of	lace, and due to the occurred at the time	e cause(s) and manne , date and place, and	er as stated. due to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (N	fonth, Day, Year)
	15		fail Banner		MO	060335	-	September	14,2009
			30. Name and address of person who completed cause of death (It	em 23a) (Type	, Print)				2-
			31. Date filed (Month, Day, Year) 37 Registrar's Sig	nature	Drive # 3	2+	Olney, N	10 208	52
	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 15 2009	1. As	eled.				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death Month 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 PM Sept. 10, 5:44 Thomas Joseph Sanzaro 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery <u>Suburban Hospital</u> Bethesda If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Months 1**X** M 2□ F Yrs June 10, 1951 Washington DC 58 215-50-1262 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1X Yes 2 □ No Chevy Chase Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20815 9228 Levelle Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 1 Married 1 ☐ Yes 2 📉 No Specify. White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medicine Medical Doctor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patricia Woodworth Frank James Sanzaro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9228 Levelle Dr. Chevy Chase, Md 20815 Kathleen M. Sanzaro / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Gabriel Cemetery Sept. 16,09 Potomac, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons 21. Signature of Funeral Service Lice Willia 5130 Wisconsin Ave N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. arteriosclerotie collowaxestas Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 | I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

Md

**Funeral** 

**Director** 

28a-f show

Director

Funeral

à

Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It. We flow Item in must be notified a once.

Baltimore, Maryland 21215-0036

AN ZALO J TUMINO COLLOS BOX 68760, Division of Vital Records, P.O. Box 68760,

Examine attending physician and for use as the burial-transil Physician/Medical After this certificate has been signed by the funeral director, page 2 should be detached ≥ Completed Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

24a. Was an autopsy performed 1 ☐Yes 2 ☐No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☑No

25. Was case referred to medical examiner? 1 ☐ Yes _ 2 ☐ No

31. Date filed (Month, Day, Year)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1. Natural 2 Accident 3 ☐ Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yeygenry Gon Chesman, un.D. 8600 Cla Googe four Rd, Benesda, uno 20814

**1**5 2009

32 Registrar's Signature

State Registrar

To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu

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			amend #5 Per FH G8	Type or Print i	in Black Ind	delible Ink.	Ensure A	II Copies	Are Legible.	
			For State Registrar	State of Mary		tificate of L			eg. No. 2009	3107
	Dhysis		1. Decedent's Name (First, Middle, Last					2. Date of Deat Month		3. Time of Death
	Physici /Medi		JOHN FRANK STENSO					Septemb	er 11 2000	11.19 am
	Examir	er	4a. Facility Name (If not institution, give	1 1		4b. City, Town, or	Location of Death	,	4c. County of Death	<u></u>
	Funeral		5. Social Security Number 6. Se	7. Age (In	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year) 9. Birth	nplace (State or Foreign untry)
	Director		410-16-02 <del>0</del> 2	DM 2□F 85	Yrs.	Months Days	Modis Mills.	8. Date of Birth (Month, Day, AUG. 5,	1924 ALAI	BAMA
	/land		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Loc	cation	- "-			10d. Inside City Limits
	h the Maryland r 28a-f show	ctor	MD CHARLES	. W	ALDORF					1 X Yes 2 □ No
)	72 hours after death with the Maryland natural", or items 23a or 28a-f show afted Examine must be notified at	Funeral Director	10e. Street and Number	D. T.ANT		10f. Zip Code		1	0g. Citizen of What Co	
-	ours after death with ral", or items 23a or Examiner must be	eral	10600 SHOOTING STA	12. Was Decedent Ever	in U.S. 13. V	20603		pecify Yes or No-	14. Race - Amer	
9	after d		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 <b>Y</b> □Yes 2□ No If Yes, Give		Vas Decedent of Hi f Yes, specify Cuba □Yes 2 XNo	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White	, etc.
21215-0036	hours :	d by	3X Widowed 4 □ Divorced	Year or Dates:						LACK
15-	in 72 t	olete	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	lurina most of work		16b. Kind of Business/I	ndustry
212	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	TAILO		,		RETAIL	
Maryland	e d ala	To Be (	17. Father's Name (First, Middle, Last) JOHN OLIVER STENSO	N			18. Mother's Nam SAVANN	e (First, Middle, A AH STENS		
Mar			19a. Informant's Name/Relationship (7)						; City or Town, State, Z	
	is 1 and 2 of Health item 27		CHRISTINE HILL/DAU  20a. Method of Disposition		20b. Place of Dispos				ORF, MARYLA	
Baltimore,	permit. Pages of Department of Important: If ite any Injury or of once.		1 X Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	ELMWOOD (	natory or other plac			IRMINGHAM,	
ati	permit. Departm Importa any Inju		21. Signature of Funeral Service Licens	2 )	72	Name and Addres				
· ·	99 E # 9	_	PAYDIA C. THORN		3/	39 LIVIN	GSTON ROA	AD, INDI	AN HEAD, MI	20640
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	remie	he a				Approximate Interval Between Onset and Death
	be sit	iner	Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of					
	execut in and ial-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a co	nsequence of):				1	
760	te be e ysiciar e buria	_		d.						
6876	certificate be iding physicia se as the bu	Medi	IF FEMALE:							
O. Box	atter for u	by Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of deli Month	ivery Day Year
Э,	w requires that the destable by the should be detached	y Ph	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the un	derlying cause give	en in Part I.	23e. Did tol	pacco use contribute to	the cause of death?
Records,	requires een sign nould be	ed b						1 □ Y€	es 2 □ No 3 □ Pr	obably 4 Unknown
ecc	law r has be	Completed						24a. Was a	y prior to d	topsy findings available completion of cause of
	i <b>clan:</b> The lav certificate has ector, page 2 :							perforr 1 🗆 Yes	ned? death? 2 No 1 Yes	2 □No
of Vital	Physician: The lar this certificate has al director, page 2	) Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	a <b>(0)</b> ED/O	Othe	Nr:	th (Check only on		
1 0	ding Phys .r After this funeral dir	n:To	27, Manner of Death	28a. Date of Injury (Month, Day, Ye	2 ER/Outpatien 28b. Time of Injury	28c. Injury	y at		ence 6 Other (Spec ow injury occurred	жту)
sior	Attending ir death. ector: After by the funer	atio	1 Natural 5 Pending investigation	(Month, Day, 16	ar) Injury		Yes 2 □ No			
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre Specify)	eet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, Stale)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral	Medical		rsician: To the best of miner: On the basis of exa						
	orthe	Mec	29b. Signature and title of certifier	and manner stated.		29c. License	e number	2	9d. Date signed (Montl	n, Day, Year)
	F > F 0		Millia 1	1. Jugou	W. MD	D-00	55088	33	Sept. 1-	1.2009
-	n.iel		30. Name and address of person who o	ompleted cause of death	(Item 23a) (Type, F	Print)	01		Sept. 1:	
	78441	i li	Yahia Tagouri 1 31. Date filed (Month) Day, Year)	10 ZS500 32. Redistrar's	FOINT L	-cokaut	Kd. L	eonardt	aun, Mo	206SO_
	Sta Registr		SEP 1 4 2	009 Servers	Signature A	and I				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Frances L. Spence 09 03 2009 /Medical 4c. County of Death or Location of Death Facility Name (If not institution, give street and number) Examiner Wicomi norage If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 8. Date of Birth (Month, Day, Social Security Number 7. Age (In vrs. last birthday) 6 Sex **Funeral** 1 M 2□F Hours Davs Months 219-36-6398 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intermed the marked other than "natural", or items 23 a or 28s-1 show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County f Health and Mental Hygiene. Item 27 te marked other than "natural", or Iteme 23a or 28a-f ehov other traumatic event, the Medical Examt, ar must be notified at TX Yes 2 No **Funeral Director** Worcester Pocomoke MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21851 110 Market St, Apt B-6 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Somerset Packing Flementary/Secondary (0-12) College (1-4or 5+) Company Laborer 7th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hattie Dashields Raymond E. Spence, Sr. ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11640 Chanmoor Way, Princess Anne, MD 21853 Denise Spence/Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition partment of Poortant: If ite 1 Murial 2 Cremation 3 Removal from State Tindley's Chapel 9-12-2009 Pocomoke, MD 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility 917 W. Isabella St Bennie Smith 21. Signature of Furural Service Salisbury, MD 21801 Funeral Home e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enterthe disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Seps15 Pheumonia Aspiration one wick **Physician** /Medical Due to (or as a consequence of). Examiner Years cancer of Squamour Busphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 99 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2/2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 068222 09-09-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wission, St Salisbury MD 2180/

DHMH 17 Rev 1/2001

State Registrar . Registrar's Sign ure

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1 - State Registrar	o /First \$4:34!-	Last)	-	Ce	rtificate of	Death	2. Date of De	Reg. No.	2009	310
ian	1. Decedent's Nam							Month	Day		3. Time of D
ical ner	Joseph A  4a. Facility Name (i		SIMONE give street and number	r)		4b. City, Town, o	or Location of Death			10 2009 County of Death	
IICI	10316 Go	lf Cours	e Road			Oce	an City		W	orcester	
	5. Social Security N			ge (In yrs. la		If Under 1 Year Months Days		8. Date of Bir (Month, Da	ay, Year)	Coui	place (State or ntry)
	Usual Residence of			71	Yrs.			April 8	, 193	38   New	York
	10a. State	10b. County		10c. City,	, Town or Lo	ocation				1	10d. Inside City
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Dir	10e. Street and Nu		a Dand			10f. Zip Code			-	zen of What Coul	ntry?
Funeral	10316 Go	II Cours	12. Was Deceden	t Ever in U.S	S. 13.	21842 Was Decedent of F	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No		JSA 14. Race - Ameri	ican Indian,
		ried 2 Marrie	Armed Forces 1 X Yes 2 If Yes, Give	™ 1955	y	If Yes, specify Cub  1 ☐ Yes 2 🖾 No		o Rican, etc.)		Black, White,	etc.
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Be	17. Father's Name		ast)		•		18. Mother's Nam	•		Surname)	
P	John Simo	one					Florence				
	19a. Informant's N Florence						t and Number or Ru urse Road				
1	20a. Method of Dis			20b. Pl	ace of Dispo	osition (Name of		Date		cation - City or To	
	1 ☐ Burial 2	•	3 Removal from State	e ce	emetery, cřel	matory or other pla	ce)			•	
	21. Signature of Fu					Cremator 2. Name and Addre	ess of Facility 12		Sams	bury, Ma	<u>arylanu</u> shurv M
	Hal	MULLA	Il In	lley			EMORIAL				1801
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9/11/2009 1:20 P M ROBERT WILLIAM SIMMS 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's 10104 Thrift Road Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/10/1943 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Min. 1**X** M 2□ F Months Days Hours 579-52-9438 Washington, DC 66 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Maryland Prince George's Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10104 Thrift Road 20735 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Xes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maryland State Roads State Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Betty Estelle Brady Richard William Simms 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernestine Carol Simms /Wife 10104 Thrift Rd. Clinton, Md. 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Lincoln Memorial 9/18/2009 Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityPope Funeral Homes, P.A. of Funeral Service Lic 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hepatrenal Syndryme
ue to (ras a consequence of):

Lina Porcellular Carcinana Immediate Cause (Final disease or condition resulting in death) Due to ( r as a consequence of): Approx seque, liaily liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once.

Physician

/Medical

10a. State

Directo

Funeral

Completed

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Examiner

**Funeral** 

Director

show

r than "natural", or items 23a or 28a-f shoothe Wedical Examiner must be notified at

e filed within 72 hours after death with I al Hygiene. other than "natural", or items 23a or ;

3altimore, Maryland 21215-0036

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Physician/Medical

To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p State Registrar

Examine burial-transit and attending physician for use as the buria signed by the a been si Completed has Be ပ Certification:

25. Was case referred to medical examiner? 1 Yes 2 No 27. Man of Death

5 Pending investigation 2 Accident 3 Suicide 4 Homicide

6 ☐ Could not be

Hospital:

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

1 Tes

autopsy 1 □Yes 2 No

24a. Was an

Other: 4 Nursing Home 5 Aesidence 6 Other (Specify)

26. Place of Death (Check only one)

D0066719

29d. Date signed (Month, Day, Year)

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Two Sapra MD 10 St. Patricell Dr # 203 Walderf MD 20603 Saprai MD

and manner stated.

31. Date filed (Month, Day, Year) SEP 1 6 2009

29b. Signature and title of certifier

29a. Certifier

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-07274 State of Maryland / Department of Health and Mental Hygiene Jeanette Schloss Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Y September 16, 2009 1310 hrs Medical Examiner Jeanette C. Schloss 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Lanham **Doctors Community Hospital** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Davs Country) Director DC 01/21/1958 M 2X F Yrs 51 577-96-5421 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No s 23a or 28a-f show e notified at once. Suitland Prince George's MD hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **UZA** 20746 3835 St. Barnabas Road, Apt. 101 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. White etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married 2 X Married 2 X No Yes Black Specify: 1 Yes 2 X No specify: If Yes. Give Year Widowed Divorced marked other than "natural", c event, the Medical Examiner þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Baltimore, MD 21215-0036 none 12 none 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucy Ann Cardwell Be Thomas Morrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) tant: If item 27 is or other traumatic 3835 St. Barnabas Rd., Apt. 101, Suitland, MD Ralph Schloss/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Removal from State 1 X Burial 2 Cremation 3 ection 09/25/2009 Clinton, MD
22. Name and Address of Facility Strickland Funeral Services Resurrection mportant: Donation 5 Other Specify: 21. Signature of Funera , ice Licensee 6500 Allentown Rd., Camp Springs, MD 20748 Mane art I. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line. /Medical Pulmonary thromboembolism Immediate Cause (Final disease xaminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and AMENDED 23a, PII, 28, per ME g895 9/29/09 TT Physician/Medical X UNPENDED ed by the attending physician detached for use as the burial Box 68760, 23d. Date of delivery 23c. If ves. outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year Month Dav 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 V Unknown ģ Rheumatoid arthritis; multiple extremities Completed 24b. Were autopsy findings available 24a Was an has been surgeries, obesity autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No page certificate 26.Place of Death (Check only one) 25. Was case referred to medical director, Be Other4 examiner? Hospital: 1 ✓ Inpatient Nursing Home 5 Residence 6 Other: DOA 2 ER/Outpatient 3 this 1 Yes No ဥ

Division of Vital Records, the Hospital or Attending Physician: After within 24 hours after death.

To the Funeral Director: A completely filled in by the fur

prior to completion of cause of 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 X Natural Yes 2 No Pending Investigation 2 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3 Could not be Suicide (Specify) Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29b. Signature and title of certifier

September 17, 2009 O.C.M.E. Lask

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Melissa Brassell, MD

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

State Registrar

Certification:

Medical

32. Registrar s Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) sept. 5, 2009 9:20a M Tebid Olive 4c. County of Death
Montgomery 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 26 Yrs. 5. Social Security Number 6. Sex 107/201/1982 Cameroon 1 □ M 2**X** F 214-69-5715 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Washington 10g. Citizen of What Country? 10f. Zip Code 20011 10e. Street and Number Cameroon 5616 13th Street N.W. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black 1X Never Married 2 ☐ Married 1 □Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Nursing Assistant Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Anong Daniel Wilson Tebid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7001 Nightingale Place Lanham, Md. 20706 Tebid Mbeh/sister Esabella 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Demoval from State 9/12/2009 Silver Spring, Md Gate of Heaven 4 Donation / 5 Dother (Spec PHITTP AD RINWLDI FUNERAL SERVICE, P.A. Funeral Service no r 9241 Columbia Blvd.Silver Spring,Md20910 olications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Be

D.C.

**Funeral** 

Director

show

is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show other traumatic event, It is Modical Exemple or must be rediffied at

2 should be filed wi and Mental Hygier is marked other th

permit. Pages 1
Department of H
Important: If iter
any injury or oth

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trans certificate be exe nse detached for the

Division of Vital Records, P.O. Box 68760,

Examine Be Completed by Physician/Medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Certification: To Medical

shock, or heart failure. List onl	y one cause on each line.	Interval Betwee Onset and Dea	
disease or condition resulting in death)	A. Hepato cellular carcinoma  Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a consequence of):		
that initiated events resulting in death) Last	cDue to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Yea	r
_	contributing to death but not resulting in the underlying cause given in Part I.  g disease, colitis	23e. Did tobacco use contribute to the cause of deat 1 ☐ Yes 2 월 No 3 ☐ Probably 4 ☐ Unk	
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings ava prior to completion of caus death?	ilable ie of
25. Was case referred to medical	26. Place of Dea	th (Check only one)	
examiner? 1 ☐ Yes 2 🖾 No	Hospital: 1X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)	
27. Manner of Death  1 ★ Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28f. Location (Street and Number or Rural Route Number City or Town, State)	ŗ

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0063343

29d. Date signed (Month, Day, Year)

Sept. 5, 2009

State Registrar

31. Date filed (Month; Day, Year) 15

IrinaRubin M.D.

29b. Signature and title of certifier

29a, Certifier

(Check only

32 Registrar's Signatu

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
IrinaRubin M.D. 1500 Forest Glen Road Silver Spring Md20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WOLFE- THOMAS Physician/ VIRGINIA Month 06:47 AM 2000 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Aug. 22, 1 - M 2 - F Days 65 1944 Maryland Director 217-42-7630 Usual Residence of Decedent or 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Myersville Frederick Maryland 1 Yes 2 X No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21773 4239 Crow Rock Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🌠 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Specify: 3 X Widowed 4 Divorced Completed Year or Dates Page 1 and 2 should be filed within 72 hours Innert of Health and Mental Hygiene. Trant: If item 27 is marked other than "natur ramt: If item 27 is marked other than "natur ramt." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U. S. Government 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Virginia Fink Mildred Raymond Thomas Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3976A Wistman Lane, Myersville, Maryland 21773 Raymond T. Wolfe, Jr/brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place) 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Smithsburg Crematory |Sept.18,2009 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Sprote Licensee 504 Main Street 22. Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final ELECTROLY 1E Ptrysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit resulting in death) Last O CANDIAL INFARCTION attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Onknown or Attending Physician: The law requires that the death Day Month Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Hinknown cate has been sig ; page 2 should b LIVER TRANSPLANTS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CAD performed? 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ဂ္ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral dir Certificate: 27, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending wark? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 28 2009

Registrar DHMH 17 Rev 7/2009 -mo

www

32. Registrar's Signature

30. Name and address person who completed cause of death (Item 232) (Type, Print)

ENN

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

HE, HASERSTOWN MO-21742

29c. License number

0064911

29d. Date signed (Month,

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryla Registrar	•	artment of Health ar rtificate of Death		Reg. No. 2009	31082
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Theodore Robert Wad	ldell		2. Date of Dea Month Sept 1		3. Time of Death 8:45 A M
3	Examin		4a. Facility Name (If not institution, give street and number) 10706 Dragoo Place		4b. City, Town, or Location of I	Death	4c. County of Dear	
	Funeral Director		•	yrs. last birthday) 75 Yrs.	If Under 1 Year   If Under 24	Hrs. 8. Date of Bir Min. Month, Da March	th 9. Bir	thplace (State or Foreign wintry) th carolina
٠	D	ļ	Usual Residence of Decedent  10a. State 10b. County 10c.	City, Town or Lo	ocation			10d. Inside City Limits
	Maryia	ţo	Maryland Prince George	Clint				1 □Yes 2 □No
	or 28e	Directo	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	
	s 23a		10706 Dragoo Place  11 Marital Status 12. Was Decedent Ever in	0116 12	20735	o2 (Specify Ves or No	United St	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, Ite Medical Evenine must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever if Armed Forces?   1	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, f 1 □Yes 2 XNo Specify:	Puerto Rican, etc.)	Black, Whit		
21215-0036	nin 72 ho e. <b>in "natur</b> Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	1 (Give	dent's Usual Occupation kind of work done during most o DO NOT use retired)	f working	16b. Kind of Business	/Industry
7	led with tygiene her tha		12	Eng	ineer	Name (First, Middle	FCC	
and	d be fil ental H ced otl c ever	o Be	17. Father's Name (First, Middle, Last)  Robert Waddell		18. Mothers		a Saulter	
Maryland	shoul and Ma s marl	၉	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street and Number	or Rural Route Numb	er, City or Town, State,	Zip Code)
€, ⊠	s 1 and 2 soft Health a ltem 27 is		Maggie C. Waddell (Wife)		06 Dragoo Place			Town State
Baltimore,	Pages 1 nent of H ant: If Ite ury or ot		1 Mai Buria   2 🗆 Cremation   3 🗀 Removal from State   1 .	laryland	osition (Name of matory or other place) Sep Veterans Cemet	ery	Cheltenham	ı, MD
Balt	permit. Departimonta	0 0	21. Signatur of Funeral Service Licensee  1. Signatur of Funeral Service Licensee  1. Love i	A	2. Name and Address of Facility ${ m lexandria}$ ${ m Ferry}$			
4.	Physician		23a Part 1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	death. Do not en		ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death 4.5 Years
	/Medical Examiner		resulting in death)  Due to (or as a con	sequence of):				J
		jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a con	sequence of):				
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a con					
68760,	ficate be executed physician and s the burial-transit	edical E	resulting in death) Last  Due to (or as a con	sequence oi).				
	ertifica ding ph e as th	Medi	IF FEMALE:			-		
P.O. Box	law requires that the death certifi as been signed by the attending . 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	Day Year
rds, P.	w requires that s been signed b should be deta	by	Part II. Other significant conditions contributing to death but not	resulting in the u	underlying cause given in Part I.	23e. Did	tobacco use contribute t Yes 2 No 3 ☐ F	to the cause of death?  Probably 4 🗆 Unknown
Division of Vital Records,	0 1 0	Completed				24a. Was auto perf 1 □ Yes		
Vita	Physiclan: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Other:	of Death (Check only		
on of	Phys r this ral dir	Certification: To	27. Manner of Death  1 Natural 5 Pending  1 Inpatient  28a. Date of Injury (Month, Day, Yea	2 ER/Outpatie 28b. Time o Injury	ent 3 DOA 4 Nurs	28d. Describe	idence 6 ☐ Other (Sp how injury occurred	ecify)
Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	ertifica	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - A building, etc. (Se	I At home, farm, st pec <i>ify)</i>	reet, factory, office		(Street and Number or F wn, State)	Rural Route Number,
	e Hospita 124 hours e Funeral letely filler	Medical C	29a. Certifier (Check only one)  1 **Mcertifying Physician: To the best of my one)  1 **Mcertifying Physician: To the best of my one and manner stated.					
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mor	
			Milaler Dellane	// CO> /=	064234		September	10,2009
1	\$10		30. Name and address of person who completed cause of death Nicholas DeMonaco, M.D. 892			Clinton. M	D 20735	
	Sta Registi							

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

		1 - For State Registrar	,	epartment of Health and Certificate of Death	Reg.	No. 2009 31084
Physic		1. Decedent's Name (First, Middle, Last Frank Wil			2. Date of Death Month Septembe	3. Time of Death 2 r 13, 2009 0957 ^M
/Med Exam		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deal	h	4c. County of Death  Montgomery
<u>_</u>		Holy Cross Hosp  5. Social Security Number 6. Se		Silver Sprine  day) If Under 1 Year   If Under 24 Hrs	_	
Funera Directo			M 2□F 52 Y	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Dec. 8, 19	Wash., DC
pu ,		Usual Residence of Decedent	10c. City, Town	ar Location		10d. Inside City Limits
laryla shov	ě	10a. State 10b. County  MD PG		ole Hills		1 <b>∑</b> Yes 2 □ No
the N 28a-f	rect	10e. Street and Number	1 Cinp	10f. Zip Code	10g.	Citizen of What Country?
h with	a D	4408 Brinkley 1	Road	20748	Ur	ited States
of ZIZIS-UUSO filed within 72 hours after death with the Maryland Hygiene. ither than "natural", or items 23a or 28a-f show ant, the Modeal Eval. The modes	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
OUCSO hours afte ural", or if	by Fi	1 ☐ Never Married 2 ☐ Married  3 ※ Widowed 4 ☐ Divorced	1 <b>∑X</b> Yes 2 □ No If Yes, Give Year or Dates:	1 ☐Yes 2X No Specify:		Specify: Black
2 hour	ted t	15. Decedent's Edu (Specify only highest grad	leation 16a F	Decedent's Usual Occupation	166	. Kind of Business/Industry
L I I	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done during most of wo life. DO NOT use retired)	rking	J. J. J. Barres
ed wii lygien ner th		12	Nu	trition Technica	ne (First, Middle, Maid	drews Air Force
d be fill be till he ed out	Be	17. Father's Name (First, Middle, Last) Unk		Mamie	wiley	ien Surname)
ITE, INTALYICATION ZINION STONDSON Stand 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercition County by motion other traumatic event, the Medical Exercition County by Medical Exercition County by Medical Exercition County by Medical Exercition County by Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercition County By Medical Exercit	2	19a. Informant's Name/Relationship (T)	/pe. Print) 19b. I	Mailing Address (Street and Number or Fi	ural Route Number, Ci	ty or Town, State, Zip Code)
, IVIC		Juliet Briscoe/		5324 4th St., Washington, DO	20011_	
DallIIIOCE, permit. Pages 1 and Department of Heal Important: If item 2 any injury or other		20a. Method of Disposition  1  Burial 2  Cremation 3	Removal from State	Disposition (Name of crematory or other place)	18/09 200	Location - City or Town, State
t. Pag rtment rtant:		4 ☐ Donation 5 ☐ Other (Specify)	Riverd	ale Park Cremato  /22. Name and Address of Facility Ho		iverdale, Md.
Dermi permi Depar Impo any ir		21. Signature of Funeral Service Licens	AUTINE	3910 Silver Hi	ll Rd., S	uitland, Md. 20746
		23a. Parl 1. Enter the disease, or comp	ications that caused the death. Do no	t enter the mode of dying, such as cardia		
Physician		Immediate Cause (Final disease or condition		enal Cell Cance		Onset and Death
/Medica		resulting in death)	Due to (or as a consequence of			
Examine		Sequentially list conditions,	b. Thrombocytop			
uted I	Examiner	Sequentially list conditions, if any, reading to instructiate cause. Enter Underlying Cause (Disease or injury	Anemia			
execuan and rial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a consequence of	):		
ficate be explicate by physician and the burial	edical		d			
entifica ling ph e as th	Med	IF FEMALE:	20. 16			
DOX sath ce	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
the de	ysic	1 □Yes 2 □No 9 □ Unknown	9 Unknown	3 - Other (specify)		
s that gned b e deta	by Pt	Part II. Other significant conditions co	ntributing to death but not resulting in t	he underlying cause given in Part I.		co use contribute to the cause of death?
v requires to been signer should be or			<del></del>		1 ☐ Yes	2 No 3 Probably 4 Onknown
law r las be	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The	Son				performed 1 □ Yes 2 □	
VILA sician certifi	Be	25. Was case referred to medical examiner?	Hospital:	Other:	eath (Check only one)	- FT-011 (0 14)
Physer this eral di	은	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury 28b. Ti	me of 28c. Injury at	28d. Describe how	e 6 Other (Specify) injury occurred
Attending Phy ar death. ector: After this by the funeral c	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Inj	ury Work? M 1 □Yes 2 □No		_
or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
pital o		29a. Certifier 1 Certifying Phy	vsician. To the best of my knowledge	death occurred at the time, date and pla-	ce, and due to the cau	se(s) and manner as stated
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical			or investigation, in my opinion, death occ		
To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
		Chap	mD	2005606	3	9/13/09
22		30. Name and address of person who o	ompleted cause of death (Item 23a) (T	ype, Print) est Glen Rd.	Silver.	Sprima MD 20910

DHMH 17 Rev 1/2001

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Mary  1 - State Registrar		rtificate of E			erie g. No. 🗇 🍴		01005
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		Bew Yee	5-			September	10	2009	3:40 a ^M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
-4"			Brighton Gardens			Chevy Chase			Montgo	
	Funeral		5. Social Security Number 6. Sex 7. Age (In 1 ■ M 2 □ F	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,		9. Birthp Coun	* '
	Director		085-28-6023 Usual Residence of Decedent	97 ris.			November 2	5, 1911		China
	and w	1		Oc. City, Town or Lo	cation				1	0d. Inside City Limits
	Mary f sh	ō	Maryland Montgomery		Chr	evy Chase				1 □Yes 2 X No
	the	Director	10e. Street and Number		10f. Zip Code	cvy onasc	10	g. Citizen of	What Coun	try?
	3a o		5555 Friendship Blvd.			20815			CI	nina
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Marical Examirer must be refilied at	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	er in U.S. 13. \	Nas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-		ce - Americ	
ထွ	after or ite		1 Never Married 2 Married 1 Yes, Give		I∐Yes 2⊠No	Specify:	Thours, cto.)	Specif		510.
8	iral",	d by	3 ■ Widowed 4 □ Divorced Year or Dates:			<i>Броспу</i> 1				Asian
, V	72 h 'natu	Completed	15. Decedent's Education (Specify only highest grade completed)	I (Give	dent's Usual Occupa kind of work done d	urina most of work		l6b. Kind of B	usiness/Ind	dustry
2	vithin sne. than	gr.	Elementary/Secondary (0-12) College (1-4or 5+)	life, L	OO NOT use retired)			1	Laundro	nmat
Š	Hed v Hygie ther t		8 17. Father's Name (First, Middle, Last)		0wner	18. Mother's Name	e (First, Middle, M			JACC
Maryland 21215-0036	the factorial liberal	Be					<b>V</b> (* * * * * * * * * * * * * * * * * * *		,	
Ë	2 should be filed vand Mental Hygie is marked other aumatic event, II	우	Unknown  19a. Informant's Name/Relationship (Type. Print)	19h Mailir	ng Address (Street a	Unknown	al Route Number	City or Town	State, Zip	Code)
Ma	d2s Ith an 17 is u		Dennis Yee - Son		Country Cl					,
	1 and Health tem 27			20b. Place of Dispo				20c. Location		wn, State
<u></u>	Pages nent of int: If its iry or o		1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place In Cremator	i .	6/2009	Brentwoo	d Mar	wl and
Baltimore,			21. Signature of Funeral Sergio: Licensee		2. Name and Addres		0/2007	DICHEWOO	d, nar	ytand
Ba	permit. Departr Importa any inji		Tomak wewan		Hines-Rinald 11800 New H				no. Mar	ryland 20904
			23a. Part 1. Epter the disease, or complications that caused the			_			169 120	Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	- L 1	es en Lie	failure				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a.  Due to (or as a co	consequence of):	repane	1 4110/6	-			I week
المميرة	Examiner		Es)	stage 1.	ver di	failure				2 weeks
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	unacquence of):	V					
7	cutec nd ransit	Examiner	that initiated events c.							
o O	e exe ian ai ırial-t		resulting in death) Last Due to (or as a co	onsequence of):						
68760,	ate b hysic he bi	edical	d	<del>.</del>						
<u> </u>	ertific ling p		IF FEMALE:							
Вох	ath co	lan/	23b. Was decedent pregnant   23c. if yes, outcome of p	☐ Fetal death 3 ☐	Ectopic pregnancy	,			ate of delive onth	ery Day Year
о О	ne de the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	me of death 5 L	Other (specify)					
σ.	that the		Part II. Other significant conditions contributing to death but n	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use con	tribute to t	he cause of death?
ds,	sign be d	l by	Henaturia	Ŭ	, ,		1 □ Ye	s 2 No	3 ☐ Prol	oably 4 🗆 Unknown
ÿ	requipernishoul	ete					24a. Was ai	n 24h	Were auto	ppsy findings available
Rec	e law has ge 2 :	Completed					autops	y I	prior to co death?	mpletion of cause of
a	n: Th ficate r, pag						1 □ Yes 2	2 No	1 ☐ Yes	2 □ No
₹	sicial certi recto	Be	25. Was case referred to medical examiner?  Hospital:	2 ED/0-4	Othe	76.	th (Check only on	1.4	h (Oi	Hospica
Division of Vital Records,	ding Physician: The In. After this certificate hiteneral director, page	Ę.	27. Manner of Death 28a. Date of Injury	2 ER/Outpatier 28b. Time of	IL 3 DOA	4 LI Nursing H	ome 5 Reside			y) nospice
o	ding th. : Afte fune	tior	1, Natural 5 ☐ Pending (Month, Day, Young to a sinvestigation	(ear) Injury		? Yes 2 □ No				
<u> </u>	Atter r dea sctor by the	lfica	3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm, str	eet, factory, office				ber or Rur	al Route Number,
6	al or s afte	Certification: To	4 ☐ Homicide determined building, etc. (	(Зреспу)			City or Towr	i, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Physician: To the best of r (Check only 2 Medical Examiner: On the basis of examiner)	my knowledge, deat	h occurred at the tin	ne, date and place	, and due to the c	ause(s) and r	nanner as	stated.
	he H in 24 he Fi	Medical	one) and manner stated		ivestigation, in my o	pinion, death occu				
	Vith Com	Σ	29b. Signature and title of certifier		29c. License			9d. Date sign		
	1		1 1hat Cl. M.O.			64129		9,11,		
			30. Name and address of person who completed cause of deat	th (Item 23a) (Type,	Print)	#7	00 (1.	. (1		0 2.815
			Breat Cole, MD 553 o 31. Date filed (Month, Day, Year) 32. Registrar's	Signature	sin avo	ive, - T	, che	vych	-25 M	(U 2381)
	Sta Registr		SI. Date filed (Month, Day, rear) 52. registrar's	A A	white.					
	ricgisti	aı	SEP 15 2009 Cekeur	15. 79.6						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1 per MD 8895 9/29/09 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Dozier B. Alford 2. Date of Death Month Physician/ 1301PM SEPTEMBER 2009 ALFORD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 6. Sex 7, Age (In yrs. last birthday) Funeral (Month, Day, Year) 4-16-1933 Days Hours Min Director S.C. 250-54-4350 76 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland at Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 □ No Baltimore N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21206 with 5510 Mayview Avenue 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or i 1 Never Married 2 Married Completed by 1 Yes 2 If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3√Widowed 4 □ Divorced Year or Dates and Mental Hygiene.
is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) National Gypsum Co Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade N/A Foreman permit. Page 1 and 2 should be filed wind Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, thousants. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Willie Metter Parrot Henry Alford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1909 Woodbourne Avenue Balto, MD 21239 1909 Woodbourne Avenue Kelly-daughter Sandra 20a. Method of Disposition, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 10-1-2009 Crownsville, MD 4 Donation 5 Other (Specify) Crownsville Vet 21. Signature of Funeral Service Licensee March East F/H 22. Name and Address of Facility Zhich W. Merce MD 21202 Balto, 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCU Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Yes Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 No Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗌 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 28624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward S. Besiman EASTERN AVENUE 4940 BALTIMORE 31. Date filed (Month, Day, Year) gistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 27. 2009 12:32P M Henry Walter Baguol Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8615 Wandering Fox Trail Apt. 106 Odenton Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Jan 26 Marviand 1945 64 215-42-6057 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2 🏹 No Anne Arundel Maryland Odenton 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 8615 Wandering Fox Trail Apt. 106 21113 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No 1963

If Yes, Give
Year or Dates. 1969 Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 ⅓ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Electronic Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever 2 Laura Dudderer Walter Henry Baguol 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 8118 Buttercup Lane Pasadena, Maryland 21122 <u>William F. Spies III, Step</u> Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State 09/28/09 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interction Onset and Death Immediate Cause (Final Muchaliae Physician/ disease or condition resulting in death) Medical Examiner ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): s been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 certificate has autopsv performed Yes 2 death? 2 AHO 1 Yes funeral director, 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: After t 28d. Describe how injury occurred Hospital or Attending 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballimore 10. Greene ST ALNOOR

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 27 CLM september 26,2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours 1 🗙 M 2 🗆 F 219-80-3257 1959 Baltimore 49 16, Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Maryland Baltimore Randallstown 1 Yes 2X No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō 3708 Offutt Road 21133 United States items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ō 1 Yes 2X No Specify. Specify: Black þ 3 Widowed 4 Divorced natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Grocery Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Brown Betty Miller ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any injury or other trau once. 3708 Offutt Road Randalstown, Maryland 21133 Michele Brown, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. September28. 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service dipensee Cremation Society of Maryland. 299 Frederick Road Baltimore, Alice Iser Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiac DYVS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury Examiner Due to (or as a consequence of) Intracratge To the Hospital or Attending Physician: The law requires that the death certificate be executed hemorrhag that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 2 - No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an finitule hae 2 No 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation (Month, Day 1 ☐ Yes 2 ☐ No death. Director: A d in by the f 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 - Homicide City or Town, State) within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

5×

State Registrar 31. Date filed (Month, Day, Year) SEP 2 9 2009

DUCKWOYTH MD

32. Registrar's Squature

32. Registrar's Squature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L.

600 North Wolfe St, Baltimore, MD, 21287

2007

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		1- For State Certific	ate of Death	Reg. No.	
Physicia	n/	Decedent's Name (First, Middle,Last)		Date of Death     Month Day Ye	3. Time of Death
ledical Examir	ner	Susan Helen Barton		September 27, 2009	1355 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County	
		114 Allessandra Court, Unit 121	Frederick	Freder	
Funeral	T	5. Social Security Number 6. Sex 7. Age (In yrs. last bit		8. Date of Birth(MM/DD/YY)	(Y) 9. Birthplace (State or Foreign
Director		220-56-4524 1 M 2X F 53	Yrs. Months Days Hours Min.	06/18/1956	Country) Maryland
	ŀ	Usual Residence of Decedent			
any	ſ	10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
nd show	닐	MD Frederick Fr	ederick		1 X Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of V	-
th the Maryland 23a or 28a-f sho notified at once	吉	117 Alessandra Court	20852	U.S.A	١.
with ns 23	펻	11. Mantal Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( Sp		ce - American Indian, Black,
leath r iten	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) Wh	nite, etc.
fler of	by F	3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:	Specify	White
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner.	륑	15. Decedent's Education (Specify only highest grade completed) 16a	Decedent's Usual Occupation (Give kind of viduring most of working life, DO NOT use reti	vork done 16b. Kind of I	Business/Industry
72 h 72 h	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti		nal Football
036 rithin 7. ene. er than	Comple	4	Administrative	Leagu	ie
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	ပ္ပ	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Maiden Surnan	ne)
De fi	8	Richard Barton, Sr.	Mildr	ed Kastana	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	٩		9b. Mailing Address (Street and Number or I		20002
MD and 2 sho alth and m 27 is aumati	-	Brianne Barton/Daughter	6070 California Cir		
Baltimore, Normit. Pages I and Department of Healt Important: If item injury or other trau			of Disposition (Name of cemetery, atory or other place)	Date 20c. Locatio	n - City or Town, State
Page Page ment o tant:			Gremation Services 09	/29/2009 Hanov	ver, Marvland
Balti Sermit. Separtn Imports njury o	- 1	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Are		
<b>a</b>	ŀ	Laura C. Hardesty MO1197	7522 Connelley Dr	ive, Ste.N, Ha	nover, MD 21076
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do rfailure. List only one cause on each line.	not enter the mode of dying, such as cardiac o	r respiratory arrest, shock, or I	heart Approximate Interval Between Onset and
/Medical xaminer	1	Immediate Cause (Final disease a. Gastrointestinal Hemorrhage		Death	
Kammer	- 1	or condition resulting in death)  Due to (or as a consequence of):			
	ᆡ	Sequentially list conditions, b.			
	Examiner	if any, leading to immediate Due to (or as a consequence of):			
	a	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
cuted nd rransi		d			
760, icate be executed physician and the burial - transit	Medical	UNPENDED			
68760, certificate be iding physic	ğ	IF FEMALE: 23c. If yes, outcome of pregnance	у		of delivery
687 ertific ding	au/	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregn	ancy Month	Day Year
Box 687 e death certification attending ted for use as t	sician	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)		
that the de detached f	Ph	Part II. Other significant conditions contributing to death but not resulti	ng in the underlying cause given in Part I.	23e. Did tobacco use co	ntribute to the cause of death?
P.O.	à	Cirrhosis of the liver, Chronic alcohol use	g	1 Yes 2 ✔ No	3 Probably 4 Unknown
ords, F w requires to a peen sign should be	ompleted	Chimodo di dia manja chima diadria da		24a. Was an 24l	b. Were autopsy findings available
Sorce law re has be 2 sho	휣			autopsy performed?	prior to completion of cause of death?
Rec The I	S			1 ✓ Yes 2 No	1 Yes 2 No
Vital Rec ysician: The his certificate director, page	Be (	25. Was case referred to medical examiner?	26.Place of Death (Check	only one)	
of Vital Records, ing Physician: The law require. The the requirement of the remain circuit cate has been some a circuit of the remain director, page 2 should be a constituted of the remain of the remain director, page 2 should be a constituted of the remain director, page 2 should be a constituted of the remain director, page 2 should be a constituted of the remain director.	P	1 ✓ Yes 2 No Inpatient 2 ER/	,		Other: Scene
Ing Ph After 1 funeral		(Month, Day, Year)	. Time of Injury 28c. Injury at Work?	28d. Describe how injury occ	curred
ion ttend leath. tor:	lği	Pending  Accident Investigation	1 Yes 2 No		
Division al or Attendi rs after death. al Director: A	ertification	3 Suicide 6 Could not be 28e. Place of Injury - At home,	farm, street, factory, office building, etc.	28f. Location (Street and Nui or Town, State)	mber or Rural Route Number, City
Divi	Cer	4 Homicide determined (Specify)			
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, d			
To the Hos within 24 h To the Fun completely	ledical	one) 2 Medical Examiner: On the basis of examination and/or and manner stated.			
	ž	29b. Signature and title of certifier	29c. License number		igned (Month, Day, Year)
		D_1	O.C.M.E.	Septemb	per 28, 2009
1 ./		30. Name and address of person who completed cause of death (Item 23a		•	
IV		Donna M. Vincenti, MD Assistant Medical Examine	er 111 Penn Street, Baltimore, N	1D 21201	
		31. Date filed (Month, Day, Year) 32. Registrar's Signature	hadel		
Regist	rar	SFP 29 2009 Jenus S. 4			

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

23,

2009

Carroll

MD.

14 Bace - American Indian Black, White, etc.

New Windsor Inn

20c. Location - City or Town, State

Winfield, MD.

& Crematory, Winfield, MD

White

4c. County of Death

10g. Citizen of What Country?

U.S.A.

16b. Kind of Business/Industry

Specify:

Month

Sept.

3. Time of Death

9:30

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2

 $\mathbf{P}^{\mathsf{M}}$ 

Carroll Hospital Center If Under 1 Year <u>Westminster</u> 5. Social Security Number 8. Date of Birth (Month, Day, Year) 08/29/1948 7. Age (In vrs. last birthday) Year If Under 2 Days Hours **Funeral ¥ 4** M 2 □ F Min 218-52-9818 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10a State 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at Director New Windsor MD. Carroll 10e. Street and Number 10f. Zip Code 106 Main St. P.O. Box 659 21776 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZANo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Milton H. Bergmann Betty Marker 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet_Connor/Daughter 4606 Highboro Ct. Mt. Airy, MD. 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State S. Carroll Crematory | 09/25/2009 4 Done 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Service Lacenses 21. Signatu Burrier-Queen Funeral Home 1212 West Old Liberty Road Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one cause on each line. te Cause (Final **Physician** disease or condition resulting in death) Acute C-V-1 /Medical Due to (or as a consequence of): **Examiner** 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-trar Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

trolled diabetes

Hospital:

5 ☐ Pending investigation

6 ☐ Could not be

determined

1. Decedent's Name (First, Middle, Last)

Yes 2 No 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death 1 Matural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

Milton Ronald Bergmann

4a. Facility Name (If not institution, give street and number)

**Physician** 

/Medical

Examiner

23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No autopsy performed' 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

or Attending Physician: funeral director, after death To the Hospital

þ

Completed

Be

Certification: To

Medical 29c. License number 29b. Signature and title of certifier 139502 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 447, EAST HAIN ST NESTMINSTER MD 2115 in 31. Date filed (Month, Day, Year) State Registrar

Mellitus

1 Yes 2 No

2 ER/Outpatient 3 DOA

28h Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

09-07434 Amy Brooking Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

у Біоокіпу		1- For State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Control State Con	ertificate of	Death		R	eg. No.		3 0 1 0 3
Physici		Registrar  1. Decedent's Name (First, Middle,Last)				Date of Dea     Month		Year 3.	Time of Death 1150 hrs
edical Exami	ner	Amy Lynn Brooking		b. City, Town, or L	ocation of Death		4c. Cou	nty of Death	
		Facility Name (if not institution, give street and number)     Sinai Hospital		Baltimore					
Funeral			s. last birthday)	If Under 1 Year	If Under 24Hrs		rth (MM/DD/Y	YYY) 9. Birthp Count	lace (State or Foreign trv)
Director		218-21-2709 1 M 2 XF 21	Yrs.	Months Days	Hours Min	Sept	8, 198		ryland
		Usual Residence of Decedent							0d. Inside City Limits
w any		ioa. Glate	ity, Town or Location						1 Yes 2 X No
yłand -f sho once.	tor	MD Baltimore	Re	istersto 10f. Zip Code	wn	<del></del> -	10g. Citizen o	of What Country	y?
ne Mar or 28:	Director	5 Sebastian Court		2	1136		U.	S.A.	
with the 18 23a se noti	a [	11. Marital Status 12. Was Decedent Ever in	13. Wa	s Decedent of Hisp es, specify Cuban,	panic Origin? (S	pecify Yes or N		Race - America White, etc.	an Indian, Black,
death or item nust b	uneral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	·   _			J 100011, 0101,	Spe		140
after ral", o	by F	3 Widowed 4 Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorced of Divorc		Yes 2 X No		work done		of Business/Inc	hite
hours "natu Exan	ted	15. Decedent's Education (Specify only highest grade completed  Elementary/Secondary (0-12) College (1-4 or 5+)	during m	ost of working life.	DO NOT use re	tired)	ļ		
336 thin 72 re. than edical	Completed	1	Admini	strative				etail S	Sales
5-06 led wi Hygier other	ပ္ပြဲ	17. Father's Name (First, Middle, Last)			18.Mother's Nam				
21215-0036 wild be filed within 7 Mental Hygiene. marked other than	o Be	Robert F. Brooking  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	g Address (Stree	Deb t and Number or	orah A Rural Route N	umber, City or	ght r Town, State,	Zip Code)
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland and Fleatht and Mental Hygiene. tti If item 27 is marked other than "natural", or items 23a or 28a-f show any other trannatic event, the Medical Examiner must be notified at once.	Ĕ	Robert F. Brooking		astian C		eisters	town.	MD 21	136
e, N l and 2 Health item 2		20a. Method of Disposition	Db. Place of Dispos crematory or ot	sition (Name of cer	metery,	Date	20c. Loca	ation - City or T	own, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	Carroll (	Cremation	ı Inc. 9			pstead	
Baltimo permit. Page Department o Important:		21. Signature of Funeral Service Licensee	·	Name and Address				rstown	
E P P E		23a. Part I. Enter the disease, or complications that caused the do	EI Do not enter I	LINE FUNE	ERAL HOM			or heart	21136 Approximate Interval
Physiciar //		failure. List only one cause on each line.	saul. Do not cher	(no moss et symg					Between Onset and Death
tamine		Immediate Cause (Final disease or condition resulting in death)  a. Head Injuries  Due to (or as a consequen	ce of):						
		Sequentially list conditions, b.							
	iner	if any, leading to immediate cause. Enter Underlying Cause	ce of):						
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequent	ce of):						1
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed for use see the burial - transit.									
60, ate be exe	Medical	IF FEMALE: 23c. If yes, outcome of	pregnancy				23d. E	Date of delivery	
3876 rtifical ling ph	1	23b. Was decedent pregnant in the past 12 months?	2 F	etal death 3	Ectopic preg	gnancy	Me	onth [	Day Year
Box 687; death certific	sician/	1 Yes 2 No 9 ✓ Unknown g Unknown	or death 5 C	Other (Specify)					
tal Records, P.O. Box 687/ cian: The law requires that the death certifical certificate has been stand by the attending p	Phy	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause	given in Part I.				the cause of death?
P.O.	3					- 11			bably 4 Unknown
rds requi	Completed						as an utopsy erformed?		completion of cause of
eco he law							es 2 No	1 🗸 Ye	es 2 No
al R	Re C	25. Was case referred to medical			Other Nu		Residence	ce 6 Othe	
Division of Vital Records, tal or Attending Physician: The law requin rs after death.		Yes 2 No	2 ER/Outpatie		ury at Work?	rsing Home 5 28d. Descri	be how injury	occurred	
n of ding l			1030 hrs	· ' · l —	Yes 2 ✔ No	Driver in	auto/truck	collision	
isio Atten er deat	1 to 1	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm, sti	reet, factory, office	building, etc.	on Tour	- Ctotol		ural Route Number, City
Div ital or ral Div	Titled in by the tune	3 Suicide 6 Could not be determined (Specify) Major				Northbour	id 795 @ O		llvd., Owings Mills, Md
Hosp 24 hos Fune	o letely in	298. Centilet . Louis to provide a transfer of my kny	owledge, death occ	curred at the time,	date and place,	and due to the o	cause(s) and late and place	manner as sta e, and due to t	ted. he cause(s)
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate	compi	and manner stated.	and/or investig		nse number				onth, Day, Year)
	2	29b Signature and title of certifier			C.M.E.		Septe	ember 23,	2009
		30. Name and address of person who completed cause of death	(Item 23a)						
		Laron Locke MD. Assistant Medical Exami		nn Street, Bal	timore, MD 2	21201			
	Sta	\FP 2 Q MIND 1/18-4300-8-2	Signature	wind					
Rec	istr	III OF I WAS FRAME AND AND AND AND AND AND AND AND AND AND	1 (1						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of N	Maryland / Dep Co		of Health a of Death		/giene Reg. No.	09	31092
	<b>D</b>		1. Decedent's Name (First, Middle, Last)					2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic				Bradley,			Septem			2:50 AM,
	Examin	er	4a. Facility Name (If not institution, give sa	reet and numbe	r)		Town, or Location of			unty of Death	
			Baltimore Wash 5. Social Security Number 6. Sex		Age (In yrs. last birthda		n Burni	24 Hrs. 8 Date of B	irth	1to 9. Birtho	place (State or Foreign
	Funeral Director			M 2□F	75 Yrs.	Months	Days Hours	Min. 100-11	1934 1934	Cour	S.C
			Usual Residence of Decedent								
	nylan how		10a. State 10b. County		10c. City, Town or	Location				1	1 ☐ Yes <b>%</b> ☐ No
	Ba-1-s	cto	MD Balto		Severn						
	oth with the Marylan 23s or 28s-1 show ust be notified at	Dire	10e. Street and Number 725 Queenstown	bood.		10f. Zip	Code 21144		•	of What Cour	ntry?
	G 09 = 1	Funeral Director		2. Was Deceder	at Ever in II S 11			gin? (Specify Yes or N		Race - Americ	can Indian.
7	after de or item	Lun	11. Marital Status  1 □ Never Married 2 □ Married	Armed Force:	s?			gin? (Specify Yes or N n, Puerto Rican, etc.)		Black, White,	etc.
036	urs at	by	3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 k If Yes, Give ² Year or Dates	X s:	1 ☐ Yes 2	No Specify:		Sp	ecify: BI	ack
RADLE 21215-003	72 ho	Be Completed by	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. De	edent's Usua	Occupation k done during mos e retired)	t of workina	16b. Kind	of Business/In	dustry
7 7	ithin Ban	nple	Elementary/Secondary (0-12)	College (1-40	or 5+)				Beth	lehem	Steel
-		Ö	8th grade  17. Father's Name (First, Middle, Last)		N/A F	urnac	e Clean	er's Name (First, Middle			. 50001
and	e d a b	Be						orine Bra		namo,	
<u> </u>	2 should and Men Is marke aumatic	ဥ	Daniel Bradley  19a. Informant's Name/Relationship (Type		19b. Ma	iling Address		er or Rural Route Num	-	own, State, Zij	Code)
FL	O1 00 W 64		Lucille Bradley				enstown		evern,		21144
DANIET altimore, Ma	s 1 and 3 if Health item 27 other tra		20a. Method of Disposition		20b. Place of Dis	position (Namematory or of	e of her place)	Date	20c. Locat	ion - City or To	own, State
C E	Pages nent of I nnt: If its ury or o		1  Burial 2  Cremation 3  Re  '4  Donation 5  Other (Specify)	moval from Sta	Bass F			-18-2009			, N.C.
βalti	permit. Page Department o Important: If any Injury or once.		21. Signature of Funeral Service License	trarel	7	_	Address of Facility E. Nor	w March I th Avenue			ID 21202
			23a. Part. Enter the disease, or complic	ations that caus	ed the death. Do not e	inter the mode	of dying, such as	cardiac or respiratory	arrest,		Approximate Interval Between
	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	A D	RATION	P	Fumo	N.A			Onset and Death
T I	/Medical		resulting in death)	Due to (or a	as a consequence of):		OISEAS	, , ,			
	Examiner		Sequentially list conditions.	PA	RKINSONS		DISEAS	E			
. 0	sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequence of).						
illo.	ate be executed hysician and the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or a	as a consequence of):						
8760,	be es	lical E		,	, ,						
687	ificate g phys	edic									
Вох	leath certifica attending ph I for use as th	Physician/Med	23b. was decedent pregnant		ne of pregnancy 2 Petal death	B⊟Ectopic pr	agnangy		23d	I. Date of deliv	•
B	deat	sicia	in the past 12 months? 1 □ Yes 2 □ No		at time of death	Other (sp				Month	Day Year
P.O.	at the d by the	Phy	9 Unknown				Q Death	22a Die	I tobacco use	contribute to	the cause of death?
Division of Vital Records,	Hospital or Attending Physician: The law requires that the death certificate be it 4 hours after death. Funeral Director: After this certificate has been signed by the attending physicial tely filled in by the funeral director, page 2 should be detached for use as the burit	þ	Part II. Other significant conditions con		Rombosi		use given in Fait		Yes 2 🗆 N		6.0
် လ	aw re	Completed	HUPERIE	NOIEN				24a. Wt	s an 2	4b. Were auto	opsy findings available ompletion of cause of
Ä	The lav ate has page 2	no.		U=m	ATIVE			pei 1 □ Yes	formed?	death? 1 ☐ Yes	
/ita	sician: Th certificate irector, pag	Be (	25. Was case referred to medical examiner?					e of Death (Check only	one)		
<u></u>	Physic rthis or ral dire	٦°	1 ☐ Yes 2 ♠No		atient 2 ER/Outpat			ursing Home 5 Re			fy)
n c	ling F	lon:	27. Manner of Death  Supering 5 Pending	28a. Date of II (Month, I	njury 28b. Time Day Year) Injur	of 2	8c. Injury at Work? 1 □ Yes 2 □		how injury o	ccurea	
isio	death death ctor: / the	lcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of	Injury - At home, farm,			28f. Location		lumber or Rur	al Route Number,
Div	al or A safter I Direction	Certification;	4 Homicide determined	building,	etc. (Specify)		,	City or 7	own, State)		
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (	29a. Certifier 1 Certifying Phys (Check only one)	icien: To the be er: On the basis and manner	st of my knowledge, desof examination and/or stated.	ath occurred investigation,	at the time, date ar in my opinion, dea	nd place, and due to thath occurred at the tim	e cause(s) an e, date and pla	d manner as s ace, and due i	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			290	. License number		29d. Date s	igned (Month,	Day, Year)
			) Sestion	m	0	y	) 4397	7	Jesten	nber	12 2009
	4		30. Name and address of person who co		of death (Item 23a) (Typ	e, Print)	1.1	0 '-	<b>V</b>		*
			unokn Okermy	- 301	torsten !	inve.	uen	(JURNZ	mo-	2100	0/1
	Sta Registr		31. Date filed (Month, Day, Year)	82. Regi	strar's Signature	red					
	3.0.		SEP AT LUUT	Marie .	- /(7						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar		Cei	rtificate of D	eath	R	leg. No. 00	31093
			Decedent's Name (First, Middle	e, Last)				2. Date of Dea	th	3. Time of Death
	Physicia		Francisco	Dario Blou	nt			Month Septemb	Day Yea	009 9:45 ам
~	/Medic Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, or L	ocation of Death	Осрссию	4c. County of D	
and.			602 East Mapl	e Road		Linthic			Anne Arı	undel
	Funeral		5. Social Security Number	6. Sex 7. Age 1	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. I	Birthplace (State or Foreign Country)
	Director		094-56-6586	TUBANI ZLI F	48 Yrs.			March 3	$0,1961 \mid 1$	Panama
	and ww		Usual Residence of Decedent  10a, State 10b. County	1.	10c. City, Town or Lo	cation				10d. Inside City Limits
	/aryli	ō		Arundel	Linthicu	ım				1 XYes 2 □ No
	the 128a-	Director	10e. Street and Number	Arunder	LIIICIIC	10f. Zip Code		1	Iog. Citizen of What	Country?
	3a or	Ö	602 East Mapl	e Road		21090			U.S.A.	·
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.	Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Sp	ecify Yes or No-		merican Indian,
ဖွ	or ite	F	1 Never Married 2 Mar	ried Armed Forces? ried 1 ☐ Yes 2 ☑ No If Yes, Give		_	, Mexican, Puerto  Specify:	Hican, etc.)		
933	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, its Medical Everting must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		TENTES ZEGINO	Specify.		Specify:	Black
2	72 h 'natu	Completed	15. Deceden (Specify only highe	t's Education st grade completed)	16a. Dece	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of work	ing	16b. Kind of Busine	ss/Industry
12	vithin	m m	Elementary/Secondary (0-12)	College (1-4or 5+)		oo not use retired) anical Ele			Service	
5	Hygie Hygie Ther I		17. Father's Name (First, Middle,		Mech			-	Maiden Surname)	
au	d d d	Be	Vicente Blou			'		Nugent	maraen camame,	
Ξ	2 should be filed within and Mental Hygiene. is marked other than sumatic event, the Ma	욘	19a. Informant's Name/Relations		19h Mailir	ng Address (Street an			r City or Town State	e Zin Code)
Σ	id 2 s Ith ar 27 is 1 trau			t / Wife	Į.	East Maple			m, MD 2109	
ē,	t and 2 f Health tem 27 i		20a. Method of Disposition	o / MITC		sition (Name of natory or other place)			20c. Location - City	
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (S		Ardent Ci		9/25/	2009	Hanover	, MD
≣	permit. F Departm Importar any injur		21. Signature of Funeral Service			Name and Address Marylan				
ñ	any any	13	Doub	e W-llais	Coll				ervices re, MD 2	21203
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused the	ne death. Do not ent	er the mode of dying,	such as cardiac	or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final	Sm a.	11 Rain	/	cer			Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of):	el Can	Cey			Jyrs
	Examiner			h						
	p ±	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of):					
1	nd	Examiner	that initialed events	с						
Ö,	be exe sian a urial-		resulting in death) Last	Due to (or as a o	consequence of):					
68760, d	death certificate be executed e attending physician and id for use as the burial-transit	Medical		d						
9 ×	ding p	_	IF FEMALE:	20a If you system of						
Box	atten atten for us	Physician	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
Ö	he de	ysic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown	ime or death 5 L	Other (specify)				
σ.	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as		Part II, Other significant condition	ons contributing to death but	not resulting in the ur	nderlying cause given	in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
Records,	uires n sign id be	d b						1 □ Y	es 2 □ No 3 □	Probably 4 Unknown
Ō	w require s been si should b	Completed						24a. Was a	un 24h Word	autoney findings available
H P	he lay e has	g						autops	med?   death	
			25. Was case referred to medica				26. Place of Deat		2€5√No   1 □ \	′es 2□No
	Attending Physician: It death. ector: After this certifically the funeral director.	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	t 2 ER/Outpatier	Othor			ence 6 □Other (5	Procify)
Division of	g Phy erthi eral c	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury a	at		ow injury occurred	респу
0	Attendin death. ctor: Aft y the fun	atio	1 X Natural 5 ☐ Pendin 2 ☐ Accident investi		Yea <i>r)</i> Injury	M 1 ☐ Ye	es 2 🗆 No			
<u>S</u>	I or Atten after deat Director: I in by the	ti	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be ined 28e. Place of Injury	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Town	treet and Number or	Rural Route Number,
5	talon rsaft al Dii	Certification:						Only or Town	n, clarcy	
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	ledical		ng Physician: To the best of Examiner: On the basis of e						
	the hin 2, the management of the F	Med	one)	and manner state						
	<u>6</u> 2 <u>₹</u> 5	Σ	29b. Signature and the of certifie	Varal so IMI	>	29c. License	18.58	2   2	29d. Date signed (M	onui, Day, Year)
		}	1 jeans	and his			, 7		sepi 2	2001
	10		30, Name and address of person	who completed cause of dea	113-11	etan A	Le K	no Ho	MD	21229
	Sta	te.	31. Date filed (Month, Day, Year)	32. registrar's		7 7 7 7 7 8		5110 1	-	
	Registra			2000	, A h	exed				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Departr	ment of Health and Me	ental Hygier	ne 2009	31094
			Registrar Certiff	cate of Death	Reg.	No.	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death
	Medic	al	Clarence J. Bled		*	r 23,2009	
	Examin	er		. City, Town, or Location of Death		4c. County of Death	
·			2626 Edgemere Avenue  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	Edgemere Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Baltimo	place (State or Foreign
	Funeral Director		1-√ M 2 □ F	onths Days Hours Min.	(Month, Day, Yea	r)Cou	
			224-20-2898		July 3,19	174 IVILE	IIIIa
	and shov	ō	10a. State 10b. County 10c. City, Town or Location	'n			10d. Inside City Limits
	Aaryl 8a-f tifie	rec	Maryland Baltimore	Edgemere			1 ☐ Yes 2 🔀 No
	the l	Ö		Of. Zip Code	10g.	Citizen of What Cou	ntry?
	s 23s	Funeral Director	2626 Edgemere Avenue	21219	τ	Jnited Sta	ites
	leath item ier m		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was If Yes	Decedent of Hispanic Origin? (Speci s, specify Cuban, Mexican, Puerto Ri	ify Yes or No-	14. Race - Ameri	
36	", or	b	1 Never Married 2 Married 1 Yes 2 X No	Yes 2   No Specify:	,	Black, White,	
Ö	tural	Completed	Year or Dates.			J WII	ite
<u> </u>	72 hc 1 "na ledic	g	(Specify only highest grade completed) (Give kind	's Usual Occupation of work done during most of working DT use retired)	g 16b	. Kind of Business Ir	ndustry
Z Z	ithin ene. • than	ပ္ပြ	Elementary/Seconday (0-12) College (1-4 or 5+)	,	"	Wingate Trucking (	ompany
מ	Hygi Hygi other ent, t	Be	8 Years Tru 17. Father's Name (First, Middle, Last)	ck Driver  18. Mother's Name (			Company
<u>a</u>	be fil ental ked ic ev	욘	D. B. Bledsoe	Fannie		,	
яZ	nd M s mar			ddress (Street and Number or Rural I		or Town, State, Zip	Code)
Š	12 stall all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all the all t			ugar Lane P.O.			26755
ē,	1 and of Hear item othe		20a. Method of Disposition 20b. Place of Dispositio	n (Name of Da	ate 20c	. Location - City or T	own, State
Ë	bage vent c nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	1 Mem. Gdns. 9/2	8/2009 1	Middle Riv	ver, MD
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	l i		me and Address of Facility da-Ruck Funeral			
m	e a T C		79	da-Ruck Fulleral 22 Wise Ave. Du	ndalk. Ma	rvland 21	222
			23a. Part T. Enter the disease, or complications that caused the death. Do not enter the	e mode of dying, such as cardiac or	respiratory arrest,	,	Approximate Interval Between
	hysician/	10	Immediate Cause (Final disease or condition	Cardio van Ular	Ula Disage		Onset and Death
	Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.	11.	, -		7.00
		L.	Sequentially list conditions, b.	hellips			- lary
_	T	dical Examiner	if any, leading to immediate Due to (or as a consequence of):				
	and /x	xar	Cause (Disease or iinjury that initiated events c			——	
	oe ex ician burial	alE	Sacrating in doctary basis				
260	phys phys the	edic	d				
89	ding se as	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	/erv
Box	atter for u	icia	in the past 12 months?	topic pregnancy her (specify)		Month	Day Year
m	the de	Physician/Me	g ☐ Unknown				
P.O.	that ined be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ds,	quires en sig uld b	ed	hypertensin		1 🗆 Yes	2 No 3 Pro	obably 4 Unknown
Ö	iw rec	Completed			24a. Was an autopsy		opsy findings available ompletion of cause of
E E	The Iz ate hiz page	No.			performed	? death?	2 □ No
g	ian: ertifica ctor, I	Be (	25. Was case referred to medical examiner?	26. Place of Death (Check of			
5	hysic his co	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	Other: 4 Nursing Hom	ne 5 Residence	6 ☐ Other (Specif	y)
5	ing P	ate:	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury injury	work?	3d. Describe how in	njury occurred	
Ö	ttend death tor: A the f	ii	3 Suicide 6 Could not be	M 1 Yes 2 No			121
Division of Vital Records,	or Ai after Direc in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, street, full building, etc. (Specify)	actory, office	City or Town, St	and Number or Rura ate)	ai Houte Number,
Ω	spital ours eral filled		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occu	red at the time, date and place, and	due to the cause(s)	and manner as stat	ed.
/	e Hos 124 h e Fun	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination and/or investigationly one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death	ion, in my opinion, death occurred at the	he time, date and pla	ace, and due to the ca	ause(s) and manner stated.
)	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	-	29b. Signature and title of certifier	29c. License number		Date signed (Month,	Day, Year)
			1 Dry 5/Jam	10059187		9-24.	> 7
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
			Derend Barren no 2 200 Holle	ins Bay in Gr	ue Ba	(timere	75515 cm
	Stat	te	31. Date filed (Month, Pay Year) 2009 432. Registrar's Signature	7			
	Registra	al C	What is a mass.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc 8895 9-29-09 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Blantz Kimberly 10:35P M September 13, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Rosedale Franklin Square Hospital If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 Yrs. 220-82-9034 4,1962 Maryland Director Feb. Usual Residence of Decedent the Maryland 1∩a State 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Expaniest must be notified at 1 Yes 2 XNo Director Rosedale Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 United States Funeral 1830 Wilhelm Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes XXNo White þ Specify Specify: 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Payroll Specialist</u> Aerotech 12 Years l Year 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ္ Robert E. Blantz Norma L. Cotingame 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21237 Mr. John E. Blantz (Brother) 1830 Wilhelm Ave. Rosedale, Maryland 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/18/2009 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List may one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Stroke disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Cerebrovascular Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of spital or Attending Physician: The law requires that the death certificate be executed ours after death.

The law spital physician and the resting the stending physician and filled in by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burish-transit Diabete( Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≨ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Selair Rd. Michael Douglas

31. Date filed (Moeth Day Year) 7602 32, Registrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State of Maryland / Depart  State of Maryland / Depart  Certi	tment of Health and M	ental Hygie	2003	31096
	Physici	an	1. Decedent's Name (First, Middle, Last)  Carl E. Bailey		2. Date of Death Month 9 / 24 / 2(	Day Year	3. Time of Death $10:35\mathrm{P}^{\mathrm{M}}$
£ 0	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	3/24/20	4c. County of Dea	ith
35 Pm	Funeral Director			If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Month, Day, Y.	9. Bir 15 Mã	thplace (State or Foreign ountry)
0.	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca	tion			10d. Inside City Limits
	Manyl	tor	MD Baltimore Baltimore	5			1 Yes 2 No
6	be filed within 72 hours after death with the Maryland tal Hygiene. sid other then "naturel", or Iteme 23a or 28a-f show event, the Medical Examination in stiffed at	by Funeral Director	10e. Street and Number 8832 Walther Blvd. 335-S	10f. Zip Code 21234	10g	. Citizen of What C	ountry?
0/	death me 23	neral		as Decedent of Hispanic Origin? (Speres, specify Cuban, Mexican, Puerto I	cify Yes or No-	14. Race - Am	
)2U 0036	rs after I', or Ita	y Fu	1 Never Married 2 Married 1 Mayes 2 No	Yes 2 No Specify:	Alcan, etc.)	Black, Whi	hite
~ેકુ ફુ-	72 hour	sted t	15. Decedent's Education 16a. Deceden	nt's Usual Occupation	16	b. Kind of Business	
2121	within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  Denti	nd of work done during most of working NOT use retired)		Dentistr	٠v
1 July 21	be filed within tal Hygiene. d other then '	3e Cc	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)	<u> </u>
15 - Annyland	should be nd Menta marked matic ev	To Be	Adam Clarke Bailey  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing.	Virginia Address (Street and Number or Rura			Zin Codel O.1 O.2 C
Ma	alth an 27 ls r			Ebenezer Road			
26  19 timore, M	ges 1 and the street or other		20a, Method of Disposition 20b, Place of Dispositi	ion (Name of D	ate 20	c. Location · City of	Town, State
3/26/	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 is marked any injury or other treumatic events.		To an area (epochy)	Name and Address of Facility Tow CK Towson Funer			Maryland 204
$\mathcal{O}_{\mathbf{m}}$	9 9 E E G	() I	23a. Part1. Enter the disease, or complications that caused the death. Do not enter		-		LU5U YORK Rd
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition and cause on each line.  Atherosclerosis	the mode of dying, such as cardiac o	respiratory arrest		Interval Between Onset and Death
	/Medical Examiner		resulting in death)  a. Trinci osciety (333)  Due to (or as a consequence of):				
(i)	\$ - 2 ₀ -	Jer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause, (Disease or injury)	•			
die	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
760,	ate be executed nysician and he burial-transit	caiE	d.				
A 89 ×	certificat nding phy use as th		IF FEMALE:				
		cian/		ctopic pregnancy Other (specify)		23d. Date of de Month	olivery Day Year
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M.	requires tha	Completed by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the under Prostate Cancer, alzhermers Duea		1 ☐ Yes		to the cause of death?
eco	e law requ has been je 2 shouk	piete			24a. Was an autopsy		utopsy findings available comptetion of cause of
上子, Vital Rec	ician: The certificate hi rector, page				performe	d? death?	s 2 No
五章	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	26. Place of Death  3 DOA Other: Nursing Hor		ce 6 □Other (Spe	ecify)
7	ding Pt	ion:	27. Manner of Death  Value of Light State of Light	28c. Injury at Work?	8d. Describe how		
Vision Vision	Attendar death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined determined 288. Place of Injury - At home, farm, street building, etc. (Specify)		28f. Location (Stree City or Town, 5		iural Route Number,
ā	Hospital or 14 hours afte Funeret Dir tely filled in		©			·	
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attendetely filled in by the funeral director, page 2 should be detached for	Medical	29a. Certifier  (Crieck only one)  Certifying Physician: 1 the best of my knowledge, death or continuous and manner stated.	occurred at the time, date and place, a stigation, in my opinion, death occurre	ind due to the caused at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	×	29b. Signature and title of certifier	29c. License number		Date signed (Mon	ith, Day, Year)
	0.04		30. Name and address of person who gamp ted cause of death (Item 23a) (Type, Pri	R171944		7/25/2009	
	. The		Michealle G. Harrison CRNP MSN 8800	Walther Blvd. Yacks	ville MD	21234	
	Sta Registr	_	31. Date filed.(Month, Day, Year)  SEP 2 9 2009  32. Registrar's Signature	9			

	1	State State Registrar	ertificate of Death		Reg. No. 2009	31097		
Physiciar		1. Decedent's Name (First, Middle, Last) Billy J. Condron, Sr.		2. Date of De Month	ber 28, 2009	3. Time of Death  2:00am M		
/Medica Examine		ia. Facility Name (If not institution, give street and number) 3000 New York Avenue	4b. City, Town, or Location of Death Baltimore High.	4c. County of Death Baltin	1			
Funeral Director		5. Social Security Number 466-16-6144 6. Sex 1234 $2\Box$ F 86 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Bir (Month, Di NOV • 2	7,1922 9. Birth	nplace (State or Foreign Intry)		
land ow	-		Location			10d. Inside City Limits		
e Mary		MD Baltimore Balt	imore Highlands			1 □Yes 2XX No		
23a or 28	rai Dire	0e. Street and Number 3000 New York Avenue	10f. Zip Code 21227		10g. Citizen of What Con United Stat	tes		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminar must be notified at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married  2 □ Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Never Marrie	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto     □Yes	ecify Yes or No Rican, etc.)		ican Indian, , etc. White		
21215-0036 d within 72 hours aff giene. r than "natural", or the Medical Exemi	mpierec	(Specify only highest grade completed) (Gin Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation ve kind of work done during most of work . DO NOT use retired) Carpenter	ing	New Home Business/I	•		
and 2	n n	12 0 17. Father's Name (First, Middle, Last) Hade Condron		e (First, Middle ark	 e, Maiden Surname)			
Maryi nd 2 should alth and Me 27 is mark r traumatii	2	19a. Informant's Name/Relationship (Type. Print)  Mable A. Condron / Wife  19b. Ma 300	iling Address (Street and Number or Ru 0 New York Avenue,	ral Route Numb Baltin	per, City or Town, State, Z Ore Maryland	ip Code) 1 21227		
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic event.		cemetery, ci	ematory or other place)	Date 1/2009	20c. Location - City or Baltimore N			
Balti permit. Departm Importa any Inju once.		21. Signature of Furnitation P. Loda, Jr	22. Name and Address of Facility harles L. Stevens 501 East Fort Aven	Funeral	Home, Inc.	1230		
		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory	arrest,	Approximate Interval Between Onset and Death		
Physician / /Medical	1	Immediate Cause (Final disease or condition resulting in death)  a.   Myncardiul  Due to (or as a consequence of):	Infarch on					
Examiner		Harakthy on						
executed an and ial-transit		Sequentially list conditions, if any, reading to time dist cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Und to Was a consequence of):  ACIVANCE Of  Due to (or as a consequence of):	dementia					
68760, 50	<b>.</b>	Due to (or as a consequence of):						
death certiff death certiff e attending d for use as	Physician/imedical		B ☐ Ectopic pregnancy 5 ☐ Other ( <i>specify</i> )		23d. Date of del Month	ivery Day Year		
P.O.		9 ☐ Unknown 9 ☐ Onknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did	tobacco use contribute to	the cause of death?		
rds, F quires that in signed I	ਨੂ			1 🗆	Yes 2 No 3 Pr	obably 45 Unknown		
The law requires that the rate has been signed by the page 2 should be detached.	Completed			perf	s an 24b. Were au prior to death? 2 ₹ \$\ \text{24b.} \text{Vere au prior to death?}	topsy findings available completion of cause of 2 ☐ No		
Division of Vital Re I or Attending Physician: The is after death. Director: After this certificate ha d in by the funeral director, page 2	e n	25. Was case referred to medical examiner?  1 ☐ Yes   Hospital:  1 ☐ Inpatient 2 ☐ ER/Outpat	26. Place of Dea			-16.1		
on of ding Phys After this funeral din	: E	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at		sidence 6 Other (Spe how injury occurred	спу)		
VISIOR r Attendin er death. rector: Af by the fur	Catic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	29f Location	(Ctreet and Number or D	ıml Pauta Numbar		
	Certification: 10	4 Homicide determined determined building, etc. (Specify)						
To the Hospii within 24 hour To the Funer completely fill	Medical	29a. Certifier  (Check only one)  1EXertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
To the within 2 To the complete	Me	29b. Signature and title of certifier  A handling Smy	29c. License number D0052490		29d. Date signed (Mont September 2			
le		30. Name and address of person who completed cause of death (Item 23a) (Type Anita Khandelwal. M.D. 1406 S. Crair		en Bur	nie MD 21061			
State		31. Date filed (Month, Day, Year) 32. Registrar's Signature			- <u></u>			
Registra DHMH 17 Rev 1/200		SEP 2 9 2009 Server S. A	ake					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-07349 State of Maryland / Department of Health and Mental Hygiene Helen Louisa Chelchowski Certificate of Death 1- For State Registrar 2. Date of Death Month Day Y September 19, 2009 1. Decedent's Name (First, Middle, Last) Physician/ 1450 hrs Medical Examiner Louisa Chelchowski Helen 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Parkville 24 West Orange Court If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Luneral Country) Hours Min. Months Davs Jan. 27,1954 Maryland **Director** 219-62-3304 м 2X F 55 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No Parkville Maryland Baltimore hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 United States 24 West Orange Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. or other traumatic event, the Medical Examiner must be Armed Forces 1 Never Married 2 X Married 2 X No Yes Yes 2 X No specify. Divorced If Yes, Give Year White Widowed r Dates \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) Itimore, MD 21215-0036 it. Pages I and 2 should be filed within 72 hot rment of Health and Mental Hygiene. rrant: If item 27 is marked other than "nat College (1-4 or 5+) Elementary/Secondary (0-12) Education Teacher Teaching 6 Years Comi 12 Years 18.Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Veronica Tyszko Donald Hopkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Husband ٩ Parkville, MD 24 West Orange Court Edward F. Chelchowski 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 2 X Cremation 3 Removal from State Burial important; 9/25/2009 Towson, Maryland Service Corp. Department Donation 5 Other Specify 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7022 Wise Ave Dundalk, MD 21222
Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approximately Approxima neral Service 21. Signature of Fa Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** Between Onset and failure. List only one cause on each line. Death /Medical a.MOrphine intoxication Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Höspital or Attending Physician: The law requires that the death certificate be executed X AMENDED 23a,27,28a-f,perM,E g896 10/2/09 TT **X 29d, per ME g897 11/24/09 TT** Physician/Medical X UNPENDED signed by the attending physician be detached for use as the burial 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE Day 3 Ectopic pregnancy Month Year 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions No 3 Probably 4 ✔ Unknown ð Yes 2 Completed 24b. Were autopsy findings available s been s should b 24a. Was an prior to completion of cause of autopsy performed' death? After this certificate has funeral director, page 2 sl 1 🗸 Yes ✓ Yes 2 No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Other₄ Residence 6 V Other: Scene Nursing Home 5 ER/Outpatient 3 Inpatient 2 ٩ 1 Yes 28d. Describe how injury occurred subject took higher dose of 28c. Injury at Work? To the Funeral Director; After t completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: Yes 2X No 1 Natura Pending prescribed medication within 24 hours after death Fd 2:22 Fd 9/19/09 pm X Accident 2 Investigation 28f. Location (Street and Number & Rural Route Number, City Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide house Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 20, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

SEP 2

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Day 27. 2009 8:45 A M Elizabeth DiPietro Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Gambrills 1361 Defense Highway 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day June 19 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** ^{'ear)}1926 1 □ M 2 🛛 F Months Days Hours Delaware 222-12-0959 Director 83 June Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5320 Dorsey Hall Drive Apt.324 USA 21042 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Specify: White 3 Nidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marie Giberson Harry Braun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5315 Tarkington Place Columbia, Maryland 21044 Daniel DiPietro, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1.
Department of I
Important: If it
any injury or or 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 09/28/09 Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory Inc. : Signature of Funeral Service Licensee Thomas Cren 299 remation Society of Maryland, Inc. 99 Frederick Road Baltimore, Maryland 21228 Gregor 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MahusTATI Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No

9 Unknown Month Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 N Other (Specify) Residence 2 - No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Get withing Trystodan. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
 Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) 10710 32. Registrar's Si State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend pt II per attending phys. G897 II/6/09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 1100 AM Davenport III Llewellyn SHITEMB Talbert 24 2009 4c. County of Death
Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Randallstown Season's Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex Min. Days 1 X M 2 □ F Months Hours 70 212-34-5714 39 MD 08 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 □ Wes 2 □ No Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code U.S.A. 21239 1903 Winford Road 12. Was Decedent Ever in U.S. Armed Forces? 1X□Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) grade completed)  $\stackrel{\text{Elementary/Secondary (0-12)}}{12th} \, \, \text{grade}$ College (1-4or 5+) Communication Chief Marines 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Talbert Llewellyn Davenport II Edith Murray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1903 Winford Road, Baltimore, Md 21239 Isabella Davenport-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 10/1/09 Owings Mills, Md 22. Name and Address of Facility
March F/H West 21. Signature of Foreral Service Licensee 60 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAL TIMOM BOSIS Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to for as a possequente of: Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Stroke, Coronary Artery Disease, Seizure, Sepsis, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension, Renal Failure autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

**Physician** /Medical Examiner Examiner and Box 68760,

**Physician** 

/Medical

**Examiner** 

Funeral Director

Completed by

Be

2

**Funeral** 

Director

2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

1 and 2 should be Health and Mental

27

permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once.

burial-trar physiciar the as for signed by the a has page certificate

Physician/Medical ģ Be Completed Medical Certification: To

29a. Certifier (Check only one)

funeral director this

Physician: The law requires that the death certificate be executed P.O. Division of Vital Records, or Attending thours after death.

uneral Director: Af ely filled in by the fur within 24 hours a

To the Funeral I

completely filled Hospital

State Registrar

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) Septembar 27 2009

ROAD COVRT

who completed cause of death (Item 23a) (Type, Print) 5401 10n OID

32. legistrar's Signature

31. Date filed (Month, Day, 29 2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Month 2009 xptem ber ZZ

1 - For State Registrar Decedent's Name (First, Middle, Last) Physician anie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 69 Months Days Hours 079-32-6342 1 M 2 K F NEW **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ms 23a or 28a-f show must be notified at AINNE ANUNDEL 1 Yes 2 No MID Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 11514 2213 NOTELY LANE Funeral Pages 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 ury or other traumatic event, the Medical Examiner must 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 Yes 2 No þ 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SEAMSTRESS SEWING 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANGELINE WESTON COWSON ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ZZ/3 NOTELYLN CROFTON MD Department of Health a Important: If item 27 is any injury or other tra once. 20b. Place of Disposition (Name of cemetery, crematory or other place) PK 20c. Location - City or Town, State 20a. Method of Disposition MEADOW RICHAR 9-28-09 ELICRIAGE, 22. Name and Address of Facility 40 WELL FUNERAL HOME 21. Signature of Funeral Service License 10220 GULFORG Rd. U 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (of as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner cardi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed line Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death
9 Unknown 5 Other (specify) ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 🔀 2 XNo 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Certification: eral Director: After filled in by the fune 5 Pending investigation 1 Yes 2 No 2 Accident after death. 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Funeral D Hospital 1-Ccertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES- 000

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BECKELEY LIMKETK.AI

September 22, 2009 600 North Wolfe St, Baltimore, MD, 21287

State Registrar 31. Date filed (Morith, Day, Year)-



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 27. 7:05 PM Orpha I. Eckhard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 10005 Fox Den Road Ellicott City Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Pay, Year) 1 □ M 2 😾 F Months Days Hours Min. Mary Land 83 Director 216-20-8400 Yrs. June Usual Residence of Decedent should be filed within 72 nouses...
and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show
I is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1X Yes 2 □ No Maryland N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3300 Benson Avenue 21227 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates. Specify: White 3 Widowed 4X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Phillip Unk. Nellie Unk. Jet 1 and 2 sh. Jepattment of Health and Important: If item 27 is many injury or other? 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10005 Fox Den Road Ellicott City, Maryland 21042 Fern Eckhard Kreis, Daughter 20b. Place of Disposition (Name of cametery, crematory or other place)
Glen Haven
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/01/09 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee Thomas 22 Name and Address of Facility
MacNabo Funeral Home, P.A.
301 Frederick Road Catonsville, Maryland 21228 Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ SMALL CELL disease or condition resulting in death) METASTATIC her TH Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Vear Pregnant at time of death g 🗌 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Tyes Yes Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a DAINE #200 COUNTS,A MO ZINYY PSIA 10700 CHAMIEN 31. Date filed (Month, Day, 32. Registrar's signatural

DHMH 17 Rev 7/2009

Registrar

	4	For State Registrar	Type or Print in I Per Phy G896 State of Marylar		ertificate of		Mentarri		20.00	31103
		Registrar  1. Decedent's Name (First, Middle, Las	st)		ertificate of	Deam	2. Date of D	Reg. No	06 000	3. Time of Death
sician		Louise Eck	Mildred	Louis	e Eck		Month Sept.	Da		1,
ledical ıminer		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town,	or Location of Dea	-		c. County of Death	
		University of Mary			Baltima					
ral or	1	5. Social Security Number 6. S	□M 25xF	. <i>last birthd</i> a Yrs.	Months Days	If Under 24 Hrs Hours Min		irth Da <i>y, Ye</i> a <i>r</i>	9. Birth	nplace (State or Foreign Intry)
		191-24-7671 Usual Residence of Decedent	79				May 4	19.	30 NOT U	n Carolina
\ <u>\</u>	- 1	10a. State 10b. County	10c. Ci	ity, Town or	Location					10d. Inside City Limits 1 ☐ Yes 2 1 No
Director		Maryland Harford  10e. Street and Number	For	rest E				10- 0	iai	
once.  To Be Completed by Funeral Director		2526 Sandy Hoo	k Poad		10f. Zip Code 2105	50		_	itizen of What Cou SA	mu y ?
Funeral	2	11. Marital Status	12. Was Decedent Ever in U	J.S. 13	3. Was Decedent of If Yes, specify Cub		Specify Yes or N	<u> </u>	14. Race - Amer	ican Indian,
		1 Never Married 2 Married	Armed Forces? 1		1 ☐ Yes 2 ☑ No		to Rican, etc.)		Black, White	, etc.
A P		3 ₩Widowed 4 Divorced	Year or Dates:							hite
Jate	1	15. Decedent's Ed (Specify only highest gra		i (Gi	cedent's Usual Occu le kind of work done . DO NOT use retire	during most of wo	rking	16b. F	Kind of Business/I	ndustry
Completed		Elementary/Secondary (0-12)	College (1-4or 5+)	1	ltor	/		Rea	alestate	Sales
Be		17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maio				e, Maidei	n Surname)	
P		Marvin Lee Weaver Ollie Gertrude (				e Cr	OW .			
		19a. Informant's Name/Relationship (Steve Murphy / S			iling Address <i>(Stree</i> Sandy Ho					
ŀ	T	20a. Method of Disposition					Date		ocation - City or T	
		Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval from State		position (Name of ematory or other pla	i	06.00			
	+	21. Signature of Funeral Service Licen		<u>lgnvie</u>	w Memoria 22 Name and Addr McComas F	L Gdn 9-	26-09	irali	Lston, Ma	ary Land
		Stally a	Hereck		1317 Coke	sbury Ro	ad, Abii	4. nador	n, MD 210	009
ı	23a. Part 1. Inter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Message	Approximate Interval Between	
		Immediate Cause (Final disease or condition Sepsis							Onset and Death	
		resulting in death)	Due to (or as a consec		0					lmonth
er		Sequentially list conditions,	b. gram negat		as in bio	00a				Intonio
Examiner		Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events								
Ex		that initiated events resulting in death) Last    C. Due to (or as a consequence of):								
dica			d							
Me	T	IF FEMALE:	23c. If yes, outcome of pregna	2024						
Physician/Medica		in the past 12 months?	1 ☐ Live birth 2 ☐ Feta	al déath 3	Ectopic pregnan	су		İ	23d. Date of deli- Month	very Day Year
VSi		1 □ Yes 2 🗷 No 9 □ Unknown	4  □ Pregnant at time of death 5  □ Other (specify) 9  □ Unknown							
by P	, 1	Part II. Other significant conditions of	ontributing to death but not res	sulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ed		1   Yes						Yes 2	s 2⊠No 3□ Probably 4□ Unknown	
Completed							24a. Wa	s an opsy	24b. Were aut	opsy findings available ompletion of cause of
Son								formed?	death?	_
å	1	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of De	ath (Check only	one)		
l:		1 Yes 2 No 27. Manner of Death	28a. Date of Injury	<del> </del>	ent 3 LI DOA	4 LI Nursing I	1		6 ☐ Other (Spec	rify)
tion		1.⊠Natural 5 ☐ Pending	1.⊠Natural 5 Pending (Month, Day, Year) Injury Work?					r now myo	ny occurred	
ifica		3 Suicide 6 Could not be determined 28e. Place of Injury, At home, farm, street, factory, office 28f. Locatio							nd Number or Ru	ral Route Number,
Certification:		4 Difficide	building, etc. (Specia	19)			City or To	own, Stat	e)	
		(Check only 2 Medical Exam	ysician: To the best of my kno iner: On the basis of examina	owledge, dea	ath occurred at the t	ime, date and place	e, and due to th	e cause(	s) and manner as	stated. to the cause(s)
Medical	+	one) 29b. Signature and title of certifier	and manner stated.			se number P24.			ate signed (Month	
		205. Signature and title of certifier	Butan	MD	290. Licen				ept., 19	
	5	30. Name and address of person who d	completed cause of death (Iter	n 23a) (Tvn	Print)	- 10000	-		-1./,	
				=5a) (Type	'''''' Meah	an Dubin	a.MD			
		22 South Gree	ne St, Bathn	voce.	MDZ	1201	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** Phillip Clifton Frazier 9/22/2009 3:05pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Tacoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/21/1952 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. Months 491-58-3317 XXM 2□ F 57 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. Count 1√2 Yes 2 □ No MD Director Prince Georges Temple Hills 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 3504 27th Avenue 20748 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: XXNever Married 2 Married 1 ☐ Yes 2 🔀 No Specify Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Community Service Org. Guidance Couselor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry Louis Frazier Rose Hamilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rebekah Daramola / Niece 1861 High Sun Drive, St Louis, MO 63031 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State Calvary Cemetery 10/02/2009 St. Louis, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service License Victor P. Doda, Jr. 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Avenue Baltimore Maryland 21230 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DIOPUL MORAR disease or condition resulting in death) Due to (or as a consequence of): Se_uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ONDSTAGE Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2. No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 5 \sup Residence 6 \sub Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 X Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

burial-transi attending physician and for use as the burial-trar certificate be ned by the o σ. signed I Division of Vital Records, page 2 should has funeral director, this I or Attending Patter death.
I Director: After the within 24 hours a Hospital completely

**Funeral** 

Director

show

28a-f

6

23a

items.

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'natural",

and Mental Hygiene.

Health em 27 i

Physician

/Medical

Examiner

Department of Healt Important: If item 2 any injury or other once. Pages 1 ment of H

72 hours after

Baltimore, Maryland 21215-0036

other traumatic event, the Medical Examiner must be righted at

Certification: To Medical

6 Could not be determined 4 Homicide

29b. Signature and title of certifier

29a. Certifier

1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year) SEPTEMBER 23 2009

PARKWAY GREETBELT MARYLAND 20770

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

325A HATTEDVE 31. Date filed (Month, Day, Year)

and manner stated

State Registra

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Patricia Ann Finley Month Day 2009 1:30 PM September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Apt. Baltimore Co. 101 Center Place Dunda1k 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 5,1948 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) Funeral Days Hours 1 □ M 2 💢 F Months Director 218-48-2655 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If tien ZT is an exted other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏝 No Dunda1k Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 United States Apt. 708 101 Center Place 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 XMarried Completed by 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo 3 ☐ Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 l h and Mental Hyglene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home 9 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary M. Wickless William C. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Middel River, MD Tiffany Keener (Granddaughter) 13219 Rivervan Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Service Corp. 9/25/2009 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Incerve 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Disease Ceronary disease or condition resulting in death) 1045 Medical Due to (or as a consequence of): Examiner capetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury pertension signed by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: ves, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an cate has I page 2 s autopsy performed prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 🗌 Yes 2/ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 💆 Natural 5 Pending work 2 Accident 3 Suicide 4 Homicide 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one) 29b, Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10085 Red Run Blod Owings, Mils

32. Registrar's Signature

DHMH 17 Rev 7/2009

29c. License number

Mary

0051552

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jerry Scott Find	on	1- For State Registrar	laryland / Departi <i>Certif</i>	ment of I ficate of I		Mental Hy	_	g. No. 20	09 3110
Physic Medical Exam		Decedent's Name (First, Middle,Last)  To rest.	Soott Fir	nch			2. Date of Death Month	Day Year	3. Time of Death 1415 hrs
		Jerry  4a. Facility Name (if not institution, give stree			. City, Town, or Lo	ocation of Death	September	4c. County of Deat	
		4405 Hooperstown Road			Taylors Island	d		Dorchester	
						If Under 24Hrs. Hours Min.		(MM/DD/YYYY) 9. Bir Forei	
any		Usual Residence of Decedent  10a. State 10b. County		wn or Location	1				10d. Inside City Limits
<b>*</b> .	_	Maryland Baltimo	, ,		Dunda	alk			1 Yes 2 X No
Maryland 28a-f show datonce,	Director	10e. Street and Number			10f. Zip Code	<u> </u>	10	g. Citizen of What Cou	ntry?
ith the Maryland 23a or 28a-f sho notified at once.	Ö	2728 Creston Road				21222		United St	ates
ath wir	Funeral	1 Never Married 2 X Married	Vas Decedent Ever in U.S. Armed Forces?		Decedent of Hispa s, specify Cuban, I			<ol> <li>Race - Amer White, etc.</li> </ol>	rican Indian, Black,
fter de I", or		3 Widowed 4 Divorced If Yes	Yes 2 No Give Year	1 Y	es 2 X No	specify:		Specify:	White
hours a nafura Xamir	ed by	or Da 15. Decedent's Education (Specify only high	nest grade completed) 16	a. Decedent's	S Usual Occupation	n (Give kind of w		16b. Kind of Business/	
36 in 72   han ", dical F	plet		ollege (1-4 or 5+)				50)	Chaol Ta	J.,
15-0036 filed within 72 hours a Hygiene "natura other than "natura , the Medical Examin	Completed	12 Years 17. Father's Name (First, Middle, Last)		Ste	eel Worke	B.Mother's Name (	First, Middle, M	Steel In laiden Surname)	dustry
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she antic event, the Medical Examiner must be notified at once	Be	Thomas Finch					th Burh		
MD 2 d 2 should lth and M n 27 is m	욘	19a. Informant's Name/Relationship (Type, P					ural Route Num unda1k,	ber, City or Town, State	
e, M 1 and 2 Health : item 2;		Mrs. Donna Finch 20a. Method of Disposition	20b. Plac	ce of Dispositi	Creston on (Name of ceme		Date	20c. Location - City or	
= s = = e		1 Burial 2 X Cremation 3 Re 4 Donation 5 Other Specify:	inoval light offace	natory or othe	Service	Corp. 9	/28/200	9 Towson,	MD
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite injury or other tr		21 Signature of Funeral Sevice Usans	En h	22. Na	me and Address of	of Facility		Dundalk,	
Physician	6 0.0	23a. Part I. Enter the disease, or complication	ns that caused the death. Do	792 not enter the	2 Wise A	ve Din	respiratory arre	Maryland 2' st, shock, or heart	L222 Approximate Interval
/Medical	9 93	failure. List only one cause on each line	e. nic Obstructive Pulmo						Between Onset and Death
tammer			(or as a consequence of):						
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
	amir	cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):							
m cuted transit	I Ex	d							
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Medical Examiner		NDED						
876( tificate ng phy:	n/Me	23b. Was decedent pregnant in the	. If yes, outcome of pregnan Live birth		I death 3	Ectopic pregnar	icv	23d. Date of deliver	y Day Year
Box 687: death certific the attending ped for use as the	sicia	past 12 months?	Pregnant at time of death		r (Specify)			N	
D. Be t the der by the a	Physician//	Part II. Other significant conditions contri	Unknown  buting to death but not resul	Itina in the un	derlying cause giv	ven in Part I	23e. Did tol	pacco use contribute to	the cause of death?
; P.O. irres that the signed by	þ	Chronic Alcoholism			,g g			2 No 3 Pro	
of Vital Records, P.O. Box ng Phystian: The law requires that the death ther this certificate has been signed by the attenent director, page 2 should be detached for u	Completed						24a. Was a		utopsy findings available completion of cause of
Recc The lavicate have	omo						perform	med? death?	
	Be C	25. Was case referred to medical examiner?	h —			of Death (Check o			
ion of Vital   trending Physician; leath. for: After this certif the funeral director,	욘	1 Yes 2 No  27. Manner of Death	I Inpatient 2 ER	VOutpatient				Residence 6  Othe	er: Scene
<b>-</b> = 7 = 1	tion	1 Natural 5 Pending	3a. Date of Injury 28 (Month, Day, Year)			es 2 No	Edd. Degembe ii	ow injury occurred	
Division tal or Attendii rs after death. at Director: /	Certification:	2 Accident Investigation 3 Suicide 6 Could not be	8e. Place of Injury - At home	e, farm, street,	factory, office bui	ilding, etc.			ural Route Number, City
_ id 2 id id	Cert	4 Homicide determined (	Specify)				or Town, St		
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the	o the best of my knowledge, e basis of examination and/o nanner stated.						
F # F 8	Me	29b. Signature and title of certifier			29c. License			29d. Date signed (Mo	
		ny ou, w,	٠		O.C.M	l.E.		September 24, 2	2009
_		<ol> <li>Name and address of person who complete Ling Li, MD Assistant Medical</li> </ol>	· ·	,	Baltimore, M	1D 21201			
		31. Date filed (Month, Day, Year)	32. Registrar's Signature	backs	9			<del></del>	
Regis	trar	SEP 2 9 2009 🔑	pour p. 19	P. Carlotte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ZANE OSWALD FLEMING 26, 2009 2:15 SEPTEMBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 617 Lee Way Street Bel Air Harford Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) Months Days Hours Min 1**X** M 2 □ F Yrs Director 226-32-0162 80 12, 1928 Virginia Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 617 Lee Way Street 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1▼Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2√€ No Specify. Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk US Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Homer (nmn) Fleming မ Mayon (nmn) Fleming 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 617 Lee Way St., Bel Air, Maryland 21014 Betty Jane Fleming / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-30-09 Air Memorial Gdn Bel Air, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTA TIC **Physician** CANCER OF LEFT disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) □Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 JUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 A No 2 🗆 No 1 ☐Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending after death. investigation 1 □Yes 2 □No 2 ☐Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide

Box 68760. P.0. of Vital Records.

Baltimore, Maryland 21215-0036

Division or Attending within 24 hours a the

> State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

ABHYA NKAR 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) SEPTEMBER 18 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BEL 41R MD 21014 INORTH AVE

82. Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 27 2009 Physician/ Forster 10:54 a M Catherine Μ. Medical 4a. Facility Name (if not institution, give street and number)
Stella Maris 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Social Security Number 7. Age (In yrs. last birthday) 91 Yrs. If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours NoWnt5 , Day, 1917 215-10-8339 MaryTand Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕇 No Timonium Baltimore Md. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What by Funeral 21093 2300 Dulaney Valley Rd. F305 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
Account Clerk Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Trageser Rose William Zeller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10718 Lakespring Way Cockeysville, Md. 21030 Ms. Jackie Lunz/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖄 Burial 2 🗌 Cremation 3 🗌 Removal from State 9-30-09 Timonium, Md. Dulaneý Valley Mem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Funeral Home, 21. Signature of Fundal Service Licens York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a co uence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 has been signed by the attending phys e 2 should be detached for use as the l IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performe Yes 2 prior to completion of cause of death? s certificate ha 1 ☐ Yes 2 ☐ No After this certification funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of s after death.

I Director: After to in by the funeral 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Secrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and #le 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) V 2300 monium 32. Registrar's Sanature

State

Registrar

29

MIDSYA.M

september.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 16:05 = DWARD aromes .0 200° /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 10/26/1951 5. Social Security Number 7. Age (In yrs. last birthday) Hours 1**X**M 2□ F 220-58-5697 57 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 ☐ No Director MD Centreville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 712 Church Hill Road 21617 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1969 1 Never Married 2 Married White 1 ☐Yes 2 X No Specify: 1973 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpet 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacob Groomes Deloris Cook 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Holly Pate/Daughter 712 Church Hill Road, Centreville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Cremation Services 09/29/2009 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licensee Zaura C. Hardesty M01197 7522 Connelley Drive, Ste.N, Hanover, MD 21076 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (r as a consequence of): elx with Carmosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 Yes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \( \sum \) Nursing Home 1 ☐ Yes 2 ☑ No Inpatient 2 ER/Outpatient 3 DOA ဂ 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner sician and burial-transit Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria that the death certificate be or Attending within 24 hours after death.

To the Funeral Director: A the Hospital

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menhal Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Ing. "Marical Examinat must be notified at once.

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10069051

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

CHRROLE AUG, TAKOMA PARIC, MO 20912

ATODO. 32. Registr 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:38 PM Scoter Janes Gorman Ser 25 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Hospit-1 SUDURS 00 8. Date of Birth (Month, Day, Yo. 3/2/1948 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Country)
Marvland Days Hours 1**⊠** M 2□ F 214-50-4981 61 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Ce artment of Health and Mental Hygiene.
my orant: If item 27 is marked other than "natural", or items 23a or 28a-f show
my injury or other traumatic event, the Medical Examinar must be recitied at 1√2Yes 2 No Director Baltimore n/a MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21223 USA 2624 Cole Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. þ 3 ☐ Widowed 4 X Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Sales 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret E. Moroschok James W. Gorman, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3650 Hineline Road, Baltimore, Maryland 21229 Gary D. Gorman / Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 10/2/2009 | Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final shock Septic hours **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed acineto Sacter Due to (or as a consequence of): Box 68760, Physician/Medical ucine to bacter IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 300 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Hospital 29a, Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 2000

32. Registrar's Signature

Baltinoic St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mmonsi

SEP 29 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per dvr., 8895,09729,093thb_ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Graham Peter Stuart ETTEMBER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL GIVES a LTIMORC If Under 1 Year | If Under 24 Hrs. 6. Sex 1 ☑ M 2 ☐ F 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** MD ountry) Months Days Hours 219-22-8446 80 Director 5-23-1929 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show 1 X Yes 2 □ No Director Baltimore City Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21223 USA 508 Sunset Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Specify: White 1 □Yes 2X No 21215-0036 If Yes, Give Year or Dates: Specify: Completed by 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) truck driver transportation is marked other 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Health and Mental Bertha White William Graham ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trauonce. 701 Mace Ave, Essex, MD 21221 Melissa Kinsler 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 9-23-2009 Baltimore MD 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 21. Signature o Funer 2719 Hammonds Ferry Road Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atheroscleratic Cardiovascular disease UNKNOWN **Physician** /Medical Due to (or as a consequence of): **Examiner** Fibrillation unknown entricular Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Subacute Basal Ganglion Infant Acute requires that the death certificate be execute sician and burial-trans P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ナルカイ // // , , /~c ivision of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has t , page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 -100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death. Ie Funeral Director: A bletely filled in by the fu 2 Accident 6 ☐Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) ithin 2 the F nplete and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 20, 2009 D0058141 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. Caton Avenue Baltimore, mo 21229 Wendie WILL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-07582 State of Maryland / Department of Health and Mental Hygiene Joseph Greeley Certificate of Death 1- For State Req. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 2331 hrs September 28, 2009 **Medical Examiner** c. County of Death 4b. City, Town or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Parkton 21320 Old York Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreior Days Hours Min. Months Country) Director MD Yrs 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Yes 2 X No hours after death with the Maryland MI Director 10q. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 320 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. Armed Forces? 1 X Never Married 2 2 X No Yes ō Specify: White Yes 2 X No specify: If Yes, Give Year Widowed Divorced δ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) other than "n t Pages 1 and 2 should be filed within 72 I treent of Health and Mental Hygiene. Manager ડી sistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be nc (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) If item 27 is MI 20c. Location - City or Town, State Itimore, I 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition crematory or other place) Burial 2 X Cremation Removal from State portant; 3 torest Hill Donation 5 Other Specify 22. Name and Address of Facility Chapel + Cremation Services-Monitor 21. Signature of Funeral Service Licenses Fuans Funeral 16924 York Road mankton mo 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Cardiac arrhythmia associated with cardiomegaly and Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Alcoholism Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical 23a,27,permE, g896 10/21/09 TT AMENDED the attending physician ed for use as the burial -X UNPENDED Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Day Year Month 3 Ectopic pregnancy Fetal death past 12 months' Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. icate has been signed by page 2 should be detach o þ 1 Yes 2 No 3 Probably 4 V Unknown σ. Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? certificate has performed' No Yes 2 1 V Yes 26. Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical of Vital Be examiner? Hospital: Other₄ Residence 6 V Other: Scene Nursing Home 5 Inpatient ER/Outpatient 3 DOA After this ို 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 X Natural Yes 2 No Division Pendina death the Director: 2 Investigation Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined To the Funeral 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 29, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 1/2001 OCME 2006

Registra

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear 23, Griffin 2009 12:15P M William A September 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X** M 2□ F Months Days Hours 219-28-3480 79 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 XYes 2 □ No MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4008 Spruce Drive 21215 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Dept. of Public Elementary/Secondary (0-12) College (1-4or 5+) Works 12th grade Superintendent Waste Water 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roland Griffin Ora Mae Warren 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Griffin-Wife 4008 Spruce Drive, Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill 9/29/09 Baltimore, Md 21. Signatule of Funeral Service Licens 22. Name and Address of Facility March F/H west 4300 Wabash Ave, Baltimore, Md 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. Immedia: Cause (Fin I disease or condition resulting in death) a. Due to (or as a consequence of): Approximate Interval Between Onset and Death Due to (or as a consequence of): Corpnar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

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Funeral

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Completed

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/Medical

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Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical ۾ Be Completed Certification: To

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State Registrar

Medical

31. Date filed (Month, Day,

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of health (Item 23a) (Type, Print)

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32 Registrar's Signature

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Baltimore, MD 21215-00; permit. Pages I and 2 should be filed within Department of Health and Mental Hygener Important: If item 27 is marked other tinjury or other traumatic event, the Med To Be Comi	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Deborah Guest - mother 2301 Sedley St, Balto MD 21230								
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To To									
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3	30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		21. Si Aure F neral ervice		le uner lon 1.A. of Ra to. C.	•					
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'Medical		failure. List only one ause on each line.  Immediate Cause (Final disease aAcquired immuno	Between Onso Death							
aminer	- 1	Immediate Cause (Final disease or condition resulting in death)  Acquired immunodeficiency syndrome  Due to (or as a consequence of):								
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nsit.	Examiner	events resulting in death) Last  Due to (or as a consequence of):								
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68 certifi nding ise as	ian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of deat	2 Fetal death 3 Ectopic pregith 5 Other (Specify)	nancy Month Day Ye	ear					
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Division of Vital Records, P.O. Box 68760, real or Attending Physician: The law requires that the death certificate be as after death.  al Director: After this certificate has been signed by the attending physicile led in by the funeral director, page 2 should be detached for use as the buri	by PI	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of dea  1 Yes 2 ✔ No 3 Probably 4 Unk	ath? known					
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ord aw rec as bee	Be			autopsy performed? death?						
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ivisic or Atte after des Directo	fica	2 Accident Investigation 28e. Place of Injury - At hor	me, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number	er, City					
ral D	Certification:	4 Homicide determined (Specify)		or Town, State)						
0 = 0 =		29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only	nd due to the cause(s) and manner as stated.  d at the time, date and place, and due to the cause(s)							
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Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 Medical Examiner: On the basis of examination and and manner stated.  29b Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)						
To the llosp within 24 hor To the Fune completely fi		one) 2 Medical Examiner: On the basis of examination and manner stated.		29d. Date signed (Month, Day, Year) September 26, 2009						
To the Hosp within 24 hor To the Fune completely fi		one)  2 Medical Examiner: On the basis of examination and and manner stated.  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 2)	O.C.M.E.	September 26, 2009						
okpend		one) 2 Medical Examiner: On the basis of examination and and manner stated.  29b. Signature and title of certifier	29c. License number O.C.M.E. 23a) er 111 Penn Street, Baltimore, MI	September 26, 2009						

09-07496

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	laryland		artmen tificate			ind M		iene ,	009	3	116
	Physici	an	1. Decedent's Name (First, Middle, L	ast)		(	•				2. Date of Deat Month	Day	Year	3. Time o	f Death
2	/Media	al	Edwin  4a. Facility Name (If not institution, g.	ive street and number)			Jrego	Town, or	Location of		Septembr		2009 unty of Death	145	A M
i	Examir	er	The Johns Hopkins I	·			Baltir			Douth			I/A		
	Funeral		5. Social Security Number 6.	Sex 7. Ag	ge (In yrs. las	**	If Under Months		If Under 2	24 Hrs. Min,	8. Date of Birth (Month, Day,			lace (State o	or Foreign
	Director			.1 <b>X</b> M 2□F	66	Yrs.	Wichiths	Days	110013	141111,	5-14-1			CARO	LINA
	aryland show d at		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						1	0d. Inside C	City Limits
	e Many ta-f sh fied a	ctor	MD. N/A		ВА	LTIMO	RE							1 XYes	2 🗆 No
	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	Director	10e. Street and Number 850 HARFORD CT.				10f. Zip-	Code 202			1	0g. Citizen	of What Coun	try?	
	ms 23	Funeral	11. Marital Status	12. Was Decedent		13.	Was Deced	lent of His	spanic Orig	jin? (Spe	cify Yes or No-		Race - Americ	an Indian,	
9	after or ite miner		1 Never Married 2 Married	Armed Forces?  1  Yes 2  If Yes, Give X  Year or Dates:	? No		If Yes, spec 1 ☐ Yes 2		Specify:	Puerto F	Rican, etc.)		Black, White,		
5-0036	hours ural", I Exa	ed by	3 Widowed 4 Divorced			16a. Dece							ecify: BLA		
	in 72   1 "nati ledica	Completed	15. Decedent's (Specify only highest g	rade completed)	E.I.)	(Give		k done d	uring most	of workii	ng	TOD. KITU	or business/iii	dustry	
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	d2 tha tha 7 is		JANET WASHINGTON								LTIMORE				
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ža	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Lice	ANTAKOZ ***	. D. н	IBNER	2. Name an	d Addres	s of Facility		LLIPS F				
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	News to to an	W 18	o k, or heart failure. List only Im nedia e Cause (Final	one cause on each lin	ne.	Λ .	er the mod	o or dynn	g, odon do v	our arac c	respiratory an	C31,		Interval Bet Onset and	tween
,	Physician /Medical		dis as or condition resulting in death)	a. CSPIFA Duelto (or as	a conse lie	ence of:	lure							-	-
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	gi; q	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	ence of):									
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0	Attending Phir death.  ector: After thi by the funeral	atior	1  Natural 5  Pending 2  Accident investigation	on (Month, Da	y Year)	Injury	м	Work'	work? 1 \( \text{Yes} \) 2 \( \text{No} \)						
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ב	vital o urs aft ral Di		29a. Certifier 1 Certifying F	Physician: To the best	of my knowle	adaa daath	a annurred	at the tim		d alana a				tatad	- 34
	Hosp 24 ho Fune etely f	Medical	(check only one)	aminer: On the basis of and manner st	of examinatio	on and/or in	vestigation,	in my of	e, date and pinion, deat	h occurr	ed at the time, o	ause(s) and late and pla	ace, and due t	o the cause	(s)
`	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fur	Me	29b. Signature and title of certifier				29c.	License	number		2	9d. Date si	gned (Month, i	Day, Year)	
8			Jully 1-	5				RES	000	)	5	epter	nber 2	5 200	9
			30. Name and address of person wh		death (Item :	23a) (Type,	Print)			200		'			
	Sta	to	31. Date filed (Month, Day Year)	Su ^ 32 Registra	ar's Signatur	re .			•	000 N	lorth Wol	re St,	Baltimor	e, MD,	21287
	ات Registr		SEP 2 9 20		~ B		Mad								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Physician/ 2009  $A^{\mathsf{M}}$ Paul Gioia 3:21 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2909 Alisa Avenue N/A Baltimore . Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 🛛 M 2 🗆 F Country) New Jersev 83 Director 157-18-1211 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 2909 Alisa Avenue U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 X Married "natural", or X Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. WII Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Expiditer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luigi Gioia Anna Decenzo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Yoshie Gioia - Wife 2909 Alisa Avenue Baltimore, Maryland 21214 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corporation 09-26-2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature Funeral Service Licensen 22. Name and Address of Facility 5305 Harford Road Umer Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Medical ATHEROSCLEROTIC GARDIOVASCULAR disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leaving to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 2 No the detached 9 Unknown P.O. I s been signed to should be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à MELLITUS Division of Vital Records, DIABETES Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of DEMENTIA has page 2 autopsy performed? Yes 2 No death? this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D3027 rulen SEPTEMBER 21, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADEN CACKE CANE SUITE DOY BALTIMONE, MALYLAND ZIZZE MILLEN 724 THOMAS

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Bay, Your) -

32. Registar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 1517 M epjember 24 2009 91 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Care altimore Ture If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex Z Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 M 2 K F 9 432-64-5350 Yrs. OCTOBER 10,1934 ARKAN Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County 1 X Yes 2 □ No NA PSALTIMORE MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 2220 KOUN KCAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) EMPLOYED BEAUTICIAN SELF YEARS 18. Mother's Name (First, Middle, Maiden Sumame) PMJ - UNIKNOUN 17. Father's Name (First, Middle, Last) SR LOUISE NORDMAN USCAR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21225 DAMS DAVCHED 2222 ROUND Rd, BALLIMOR, MD SAMMIE 20b. Place of Disposition (Name of cometery, crematory or other place) 555EPH H. CREMATRY C9/25/2009 FUNCERAL HOME+ CREMATRY 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State BALTIMORE, MARYLAND 1 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 505EPH H. CROWN JR. FUNERAL HOME SIHON. FULTON AVE, BALTIMORE, MD 21217 21. Signature of Funeral Service Licenses illam) unc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonio disease or condition resulting in death) Due to (or as a consequence of): ue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last b SiS Due to (o as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

**Physician** 

/Medical

Director

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Baltimore, Maryland 21215-0036

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P.O.

Division of Vital Records,

State

Registrar

Hospital: 1 ☐ Inpatient Cthen 4 ▲ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2💢 No 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 🗌 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier Nacem majur

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Street NAFEM 5 Dolphin 0

31. Date filed (Month, Day, Year) SED 2 0 2000

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		laryland / De	partmer Certifica					Reg. No.	2009	31119
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Clara Lelia Hopk	ins						Date of De Month	24°,	2009	3. Time of Death 8:18 P _{•M}
	Examin	er	4a. Facility Name (If not institution, 102 Wheel Court	give street and numbe	r)		Town, or Air	Location o			Har	ounty of Deat ford C	o.
	Funeral Director		5. Social Security Number 218–28–0176	. Sex 1 □ M 2 1 F	nge (In yrs. last birthd 78 Yrs	Months	r 1 Year Days	If Under a	Min. A	B. Date of Bit Apr 1	rth av. Year) 8, 19	9. Birt 31 Mar	hplace (State or Foreign whtry) yland
	rryland show		Usual Residence of Decedent  10a. State 10b. County	2 0	10c. City, Town or	Location							10d. Inside City Limits
	h the Ma or 28a-f	Director	Maryland Harfor  10e. Street and Number	d Co.	Bel Air	10f. Zij					10g. Citize	en of What Co	1 □ Yes 2X No untry?
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9200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Examinatory and the natified at once.	þ	1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1  Yes 2 2 If Yes, Give Year or Dates		I3. Was Dece if Yes, spe 1 □ Yes		Specify:	i, Puerto Ri	can, etc.)		Black, White Specify: Whi	e, etc.
215-(	hin 72 h e. an "natu Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-4o	(G	ecedent's Usu iive kind of wo e. DO NOT u	al Occup ork done d se retired	ation during most ()	t of working		1	d of Business/	
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Mar	und 2 sho alth and 1 <b>27 is</b> m er traum		19a. Informant's Name/Relationship Charles H. Hopki			ailing Address Wheel (	•					Town, State, 2 21015	Zip Code)
imore	Pages 1 ament of He ant: If Item ury or other		20a. Method of Disposition 1 ☐ Burial 2 🏅 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		20b. Place of Dicemetery, CEANS F	crematory`or o	other plac	pel S	Sept. 2009	^{1e} 29,		ation - City or st Hil	Town, State 1, Maryland
Balt	permit. Departi Import any Inj once.		21. Signature of Funeral Service Lie	censee		Evans 1 3 Newp	Addres Funei ort I	al Ch Orive,	hapel , For	& Cr est H	emati	on Ser Maryla	vices -BelAi nd 21050
	Physician		23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition 2 C • V • A •										Approximate Interval Between Onset and Death 1 0 Y
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2/2	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause Filst I users Cause (Disease or injury that initiated events		s a consequence of):								30 y
8760, M	ate be executed hysician and he burial-transit		resulting in death) Last	Due to (or a	s a consequence of):								
P.O. Box 68	ath certific attending p or use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal death at time of death	3 ☐ Ectopic   5 ☐ Other (s		<i>y</i>			23	d. Date of del	ivery Day Year
ds, P.	ires that the de signed by the a I be detached t	þ	Part II. Other significant condition	s contributing to death	but not resulting in the	e underlying o	cause give	en in Part I.		10			o the cause of death?
Division of Vital Records,	The law requir cate has been s page 2 should I	Completed								24a. Was auto perfe	an psy ormed?	24b. Were au prior to death?	ntopsy findings available completion of cause of
/ital	clan: T ertifical ector, pa		25. Was case referred to medical examiner?	10.1		· · · · · · · · · · · · · · · · · · ·			of Death (	1 ∐Yes Check only	2 ŽNo one)	1 LIYes	2 🗆 No
of	ding Physician: h. After this certific funeral director,	<u>ان</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death		tient 2 ER/Outpa			4 🗆 Nu	· • •	e 5 Res		☐Other (Spe	cify)
27. Manner of Death  12 Natural  13 Natural  28a. Date of Injury  (Month, Day, Year)  28b. Time of Injury  M  12 Natural  2									28f. Location (Street and Number or Rural Route Number,				
Div	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the		4 Homicide determine	building,	etc." (Specify)					City or To	wn, State)		
	he Hosp in 24 ho he Fune pletely f	Medical	29a. Certifier (Check only one) Certifying 2 Medical Expone)	Physician: To the best aminer: On the basis and manner	of examination and/o	eath occurred or investigation	at the tir	ne, date an pinion, dea	nd place, ar ith occurred	d due to the	e cause(s) a , date and p	and manner a place, and due	s stated. to the cause(s)
	To t with To t	Σ	29b. Signature and title of certifier	Mar	7)		c. License			9		signed (Mont 2009	h, Day, Year)
	20		30. Name and address of person wi		death (Item 23a) (Typ.		Re	oad.	Bela	ir, I	WD 21	015	
	Sta Registra	LC	31. Date filed (Month, Day, Year)	2. Regis	trar's Signature	all l				<u> </u>	ا کے بید.	013	

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name, (First, Middle, Last) 2. Date of Death Physician M, Hon Month 335 AM 247 26200 C /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Mar. niversit land Himore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 180-46-Months Days Hours Min, 1 M 2 □ F 5 Director 060 PAUsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exemitar in an terminal at 10d. Inside City Limits Director 1 ☐ Yes 2 📉 No MD Prince Georges Glenn Dale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6014 Glenn Dale Road 20769 Funeral U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2**X** No Specify: Specify: 3 Widowed 4 X Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the "Mode. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 4yrs Technology Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ulysses T. Hamiel Verna Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ulysses T. Hamiel-Father 1360 Harlow Street, Pittsburgh, PA 15204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Allegheny Cemetery 10/3/09 Pittsburgh, PA 22. Name and Address of Facility Coston Funeral Home, 427 Lincoln Ave, Pitt Inc Lincoln Ave, Pittsburgh, PA 15206 23a. Par J. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immer late Cause (Final MUK. **Physician** -organ discase or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 051 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Sat 2022t resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide

Physician: The law requires that the death certificate be executed burial-trar Box 68760. attending physician for use as the buria P.O. signed I Records, funeral director, page 2 should certificate of Vital this After 1 Division or Attending

death with the Maryland

within 72 hours after

Maryland 21215-0036

Baltimore,

within 24 hours after death. filled in by the To the Hospital

Certification: To

29a. Certifier (Check only one)

4 Homicide

Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature_and title of certifier wens 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greene JT

Location (Street and Number or Rural Route Number, City or Town, State)

om 31. Date filed (Month Day, Year)

MD

State Registrar

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Month Year Hill Richard SEPTEMB Za EX 26 4b. City, Town, or Location of Death 4c. County of Death Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, 10 2 6 6 Sex 7. Age (In vrs. last birthday **№** M 2 🗆 F 90 MD 10b. County 10c. City. Town or Location Baltimore NΑ 10f. Zin Code 10g. Citizen of What Country?

1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 720AM Eugene /Medical 4a. Facility Name (If not institution, give street and number) Examiner Season's Hospice 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 213-18-9598 Director Usual Residence of Decedent 10a. State 10d. Inside City Limits show other traumatic event, the Medical Examiner must be notified at Director MD 1 X Yes 2 □ No 28a-f 10e. Street and Number items 23a or 21207 U.S.A. 3828 Southern Cross Drive Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14 Bace - American Indian hours after 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☐ No Specify. ۾ Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 h (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "n any injury or other transmitted." Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Crane Operator Beth Steel Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kate Smith Charles Augustus Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3828 Southern Cross Drive, Baltimore, Eva Patterson-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/2/2009 Woodlawn Woodlawn, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimaore, Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a ACUTE CENEBROVASCULAR THROMBOSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Duc to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a d be detached f Ö 9 Unknown 9 Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy certificate performed 1 ☐ Yes 2 ☑ No 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1∐Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 🕅 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD COURT RD RANDALISTOWN 5401 31. Date filed (Month, Day, Year, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** sept. Mary Theresa Holland 2009 4:50 AM. /Medical a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford County 8. Date of Birth (Month, Day, Year)
Oct. 26,1925 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral Days Hours 1 □ M 2 T F Months 219-18-2508 83 Director Ohio Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, it is invitoral Evolution or other traumatic event, it is invitoral. Director PA 1 Yes 2 No York County Delta 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 64 Clubhouse Road 17314 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 □Yes 2 No Specify 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NQT use retired) Elementary/Secondary (0-12) College (1.4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tom Conovich Anna Welsh ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Nick Stallings (Nephew) 21 Dogwood Road, Airville, PA 17302 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/30 Oaklawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation 3 Newport Drive, Forest Hill, MD Services 21050 EANT M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEU MONIA disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting doubt), act Physician/Medical Examiner Due to (or as a consequence of): physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ LUNG DISEASE INTERSTITIAL 3 Probably 4 ☐ Unknown Completed 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform 1 ☐Yes 2 ☐ No Vital 1 ☐ Yes 2 PNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ð 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Division or Attending 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING DO21207 2009 PHYSICIAN 26 SEPT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VELGA - CAMBLLERI 21286

DHMH 17 Rev 1/2001

Registrar

Holland,

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5. MIDCREST CT.

BALTIMORE

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year September 24, 2009 **Physician** Donald Givens Hanna 13:45 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Harford Harford Memorial Hospital Havre de Grace If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 🔯 M 2 🗆 F 11, 1932 Director 220-30-6034 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Inc Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Bel Air Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2306 Turner Lane 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Vehicle Maintenance Supervisor State Government</u> is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vera Gertrude Givens P James Harry Hanna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Frances Hanna / Wife 2306 Turner Lane, Bel Air, MD 21015 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition cof P. Hits. Pages 1 D partment of Important: If it are injury or once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Memorial Gd. 9-28-09 4 ☐ Donation 5 ☐ Other (Specify) Fallston, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the leafn shock, or hear failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death **Physician** TWO BAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OBSTRUCTIVE Over 10 Yugan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): physician a the burial pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page ; performe this certificate 1 ☐ Yes 2 No 1 □ Yes al or Attending Physician: Ts after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral E Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier DO056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 South Union Ave., Havre de Grace, MD 21078 Jason Birnbaum, MD 31. Date filed (Month, Day, Year) SEP 2 9 2009 32. Registrar's Signature State ( andies Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ε. Herndon Day James 19. 2009 September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Nottingham 9 Hoban Court 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Tune 2 Davs 1 X M 2 □ F Months Hours Min. Country) West Virginia Director 85 Vrs 1924 236-24-2711 June Usual Residence of Decedent show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director 28a-f Nottingham 1 Yes 2 No Baltimore Maryland ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21236 9 Hoban Court United States "natural", or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give 2 No Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 😾 Widowed 4 🗀 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Steel Industry Steelworker 8 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Katherine Gabbert Ottie R. Herndon other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Warvland 21236 19a. Informant's Name/Relationship (Type, Print) Daughter Nottingham, Maryland Mrs. Theresa Herndon Mowry 9 Hoban Court Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State any injury or 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Middle River, MD Holly Hill Mem. Gdns: 9/24/2009 ►☐ Donation 5 ☐ Other (Specify) 21, Signat of Funeral Service Licenser Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1 Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition CHROVE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans al that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for I in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 WUnknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an nas autopsy this certificate Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, it Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🐼 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury_at Certificate: 28d. Describe how injury occurred 5 Pending 1 🔯 Natural injury 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0201

32 Pregistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#19b, perFH, G896, 10/1/09, WS.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Johnson Sr. 👗 M Alexander Sextember 2009 1:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltmore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min **Director** 81 229-34-3819 03 VA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, it is Itedical Examinating must be matthed at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore MD 1. Yes 2 □ No Director NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2502 West Coldspring Lane 21215 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify. Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 8th grade Beth Steel Corp. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Richard Johnson Richetta Macklin ပ 19a. Informant's Name/Relationship (Type. Print) 195 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau once. Etha Johnson-Wife <del>2512</del> West Coldpsring Lane, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Garrison Forest Vet 9/29/09 Owings Mills, Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West I one 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1 Enter the disease, or complications that caused the doath. Do not enter the mode of dying, such as cardiac or respiratory arrest, should or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lieute or njury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> coronary artery disease BPH 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 K No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P. Damisse MO 305-000 September 21,2009

DHMH 17 Rev 1/2001

State Registrar

,2401 W. Belvedere Ave Baltimore MD 21215

of Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Surge

Pamela Dana 35e, HD
31. Date filed (Month, Day, Year)
SEP 29

Hespital
32. Registrars S

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 1:13 PM Jolly Alexander /Medical 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Balto N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Months Days Hours Min. M 2□ F 66 7-4-1943 Director 214-40-8399 S.C. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show event, the Medical Examiner must be notified at Director 1√ Yes 2 No MD N/A 28a-f Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1039 N. Aisquith Street SA 21202 IJ Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married Maryland 21215-0036 "natural", or 1 ☐Yes 2 No Specify: Black Specify ₫ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter 12th College Food Depot is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be s 1 and 2 should be fi f Health and Mental F Arthur Jolly Pages 1 and 2 should I Beatrice ဥ Boyd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 1039 Acquanetta W. Jolly-Wife N. Aisquith Street Balto, MD 21202 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Greenmount 9-29-2009 Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H Wan 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical 687 Box IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a I be detached f Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Be Completed page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performe 1 ☐ Yes 2 No Division of Vital 1 □Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ★ Other (Specify, After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1. Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the bor to fmy knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and man, ar stated. (Check only one) within 2 the 29b. Signature and title of certifier

F State Registrar

30. Name and address of person who

Year)

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

1.13pm

ise of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sphiember ames 1:30 P M 2009 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City. Town, or Location of Death Examiner IA Hos Bonsecours pital BALLIMORE 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Funeral Days 1 M 2 F Months Hours Min. 579-40-8472 Director unknown Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Tes 2 No Director 11 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 1000 Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ Yo if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 🖼 🗖 o Blac Specify 2 Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Ir. & M. nknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nknown JOWK 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21202 suardian 10 N. Himore 20b. Place of Disposition (Name of cemetery_crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltinou 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service License 22. Name and Address of Facility tower 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician U disease or condition resulting in death) /Medical Due to (or as a c x s quence of): Examiner Sequentially list conditions, if any, leading to him addate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □No o been signed by the should be detached 9 I Unknown 9 ☐ Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Dreumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? 1 □ Yes 2 🛣 No certificate Division of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ပ္ 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After t Certification: 28c. Injury at Work? 1 XNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and little of dertifier

one)

30. Name and addre

icardo

Hospital Secours 32. Registrac's Signature

s of person who completed cause of death (Item 23a) (Type, Print)

,2000

29c. License number

West Baltimora street

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 25, 2009 **Physician** 2:25 P. Myrtle Marie Jackson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Regency Assisted Living Gambrills Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth October 7, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2 🙀 F 212-09-3523 92 Marviland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination at the notified at once. 28a-f show Maryland Anne Arundel Gambrills 4 1 1 ☐ Yes 2 X No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 730 MD. Rt. 3 South 21054 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Architecture Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Englehart John Vahle ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Jackson/Son 4219 Fullerton Avenue Baltimore Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/30/09 Gardens of Faith Baltimore Maryland 22. Name and Address of Facility Leonard J. Ruck Tho 5305 Harford Road Baltimore Maryland 21214 21. Signature of Furieral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on enal line. Immediate Cause (Final . Physician Me disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months
1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 □ Yes 2 1 NO 2 | M Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | ₩o 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation eral Director; A 1 ☐ Yes 2 🗌 No 2 Accident 3 ☐ Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title V L009 of death (Item 23a) (Type, Print) of person who completed cause mo 32. P

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Sept. David Charles Killary 26 2009 8:30 AM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** 12246 Roundwood Rd. Unit 304 Timonium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 20 1925 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 008-14-5960 84 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12246 Roundwood Rd. Unit 304 21093 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2X Married 2 🔲 No white 1 ☐ Yes 2 🗙 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Graphic Arts Elementary/Secondary (0-12) College (1-4or 5+) 12 Majority Owner/Chief Executive Equipment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)

20b. Place of Disposition (Name of cemetery, crematory or other place)

oronar

Due to (or as a consequence f):

Due to (or as a consequence of)

Due to (or as a consequence of)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Atlantic Crematory

ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

3 Ectopic pregnancy

28c. Injury at Work?

1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

1 ☐ Yes 2 ☐ No

5 ☐ Other (specify)

Marjorie Dodds

9/29/09

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093

20c. Location - City or Town, State

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

Towson,

Glen Burnie, MD

Approximate Interval Between Onset and Death

Year

12246 Roundwood Rd., Unit 304, Timonium, MD

^{22. Name and Address of Facility}
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093

24a. Was an autopsy performed

2

28d. Describe how injury occurred

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

6701 N. Charles St.,

26. Place of Death (Check only one)

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event. **Physician** /Medical

Examiner Examine

Physician/Medical

9

Completed

Be

Certification: To

Medical

State

**Physician** 

/Medical

**Examiner** 

10a, State

MD

Charles E. Killary

20a. Method of Disposition

21. Signature of plune of Service Lice

Bryan

Immediate ause inal disease or resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

1 ☐ Yes 2 ☐ No 9 Unknown

in the past 12 months?

25. Was case referred to medical examiner?

_2 No

1 ☐ Yes

27. Manual of Death

1 Natural

2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certific

Daniel B.

31. Date filed (Month, Day, Year)

SEP 29 2009

resulting in death) Last

IF FEMALE:

4 □ Donation

19a. Informant's Name/Relationship (Type. Print)

Janice Sharp Killary/wife

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

Clar

Ever the disease, or complication, that can be referred to the result of the cause on ear

rhematord arthritis

5 Pending

investigation

determined

Levy,

6 ☐ Could not be

5 ☐ Other (Specify)

w.

Director

Funeral

Completed

Be

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**Funeral** 

**Director** 

filed within 72 hours after death with the Maryland Hygiene.

Hydiene "natural", or Items 23a or 28a-f show

ir than "natural", or items 23a or 28a-f show the Modeal Examiner must be rufffled at

attending physician and for use as the burial-tran After this

Division of Vital Records, P.O. Box 68760 or Attending Physician: death. Director: within 24 hours a

Registrar DHMH 17 Rev 1/2001 GBMC Suite 5105,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM 5 per FH G926 14 63 42012 and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Kline George September 24, 2009 9:29 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 🔀 M 2 🗆 F Months Days Hours 04/27/1928 Director 81 Maryland Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Examinet must be notified at Director 1 ☑ Yes 2 ☐ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 5010 Oaklyn Avenue 21206 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Tyes 2 No If Yes, Give Year or Dates: 1954–56 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tool Maker Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Kline. Marie ပ Dorbert. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James L. Kline, Son 39 Caterham Court, Rosedale, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial 09/28/2009 Timonium, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. Donard War 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ancer /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) the the 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 22XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural n 24 hours are. he Funeral Director: Af 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pavill

State Registrar Year

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** James P. Karukas 26, 2009 September 7:47 A. /Medical Facility Name (If not institution, give street and number) Good Samaritan Hospital 4c. County of Death N/A 4b. City. Town, or Location of Death Examiner Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Date of Birth (Month, Day) 1^{Year)} 1953 1 **№** M 2 🗆 F Months Days Hours Min. 55 215-58-1617 December 1, Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, it a Meule Newmer must be notified at N/A Director Maryland Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 USA Funeral 3904 Southern Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: ð Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Restaurant Work Food Industry and Mental Hygins Is marked other 18. Mother's Name (First, Middle, Maiden Surname) Helen Kakkinakis 17. Father's Name (First, Middle, Last) Be Peter James Karukas ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 ls 14 Crescent Hollow Court Ramsey New Jersey 07446 George Kakkinakis/Uncle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If iter any injury or oth Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 9/29/09 Greek Cemetery Woodlawn Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leopard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 hutu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onse and Death Immediate Cause (Final Physician 00 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to him edisticause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dire to (or as a consequence of) signed by the attending physician and I be detached for use as the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been si page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 12 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 ₹No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed P.O. Box 68760, of Vital Records, Division

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

certificate I or Attending Physician: after death. After this within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu To the Hospital

State Registrar

Medical

lerrance 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

ena

4 Homicide

29a, Certifier

L. Bakernn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

29c. License number
29d. Date signed (Month, Day, Year)
September 26 2009

(Type, Print)
Cood Sanaritan Hospital, Bultimine 32. Registrar's Signature

1 retitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Richard Andrew Kraft September 20,2009 8:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Heritage Nursing Center Dunda1k Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 15x M 2□ F 218-32-0947 Director Maryland June 2,1939 70 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Dunda1k Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21224 items 23a 978 Dalton Avenue United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 DYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement Police Officer 12 Years Department of Health and Mental High Important: If item 27 is marked other any injury or other traumatic event, In once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Mildred C. Langhirt Andrew J. Kraft, Jr. 19a. Informant's Name/Relationship (Type. Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 978 Dalton Ave. Baltimore, Maryland Mrs. Marguerite J. Kraft 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer Cem. 9/24/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Hanl 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DNF Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence 1) Examiner LTIM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) certificate has been signed by the a sector, page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 100 1 ☐ Yes 2 ☐ No After this certific funeral director, 25. Was case referred to dical examiner? Be 26. Place eath (Check only one) Hospital: Other: 1 Tes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 A atural after death.

Director: Af
d in by the fur 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospita 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. the 29b. Signatur 29d. Date signed (Month, Day, Year) License number TEMBER 20,200° 410-A AND 31. Date filed (Manual)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fb 8895 9-30-09 to State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death SEPTEMBER I'V 1009 Howard Francis King, Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) or Location of Death 4b. City, Town, FRAY FO N7

If Under 24 Hrs. 8. Date of Birth (Month, Day, HEALTH PARE 9. Birthplace (State or Foreign Country) Massachu setts 5. Social Security Number If Under 1 Year 6. Sex Days 1 XM 2 ☐ F 5-29-1936 021 28 4725 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No Maryland Harford Aberdeen 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 501 S. Parke Street 21001 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ es 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married If Yes, Give Year or Dates:1958–1973 1 ∐Yes 2 XXNo Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Administration Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Francis King, Sr. Karin Axelsson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick J. Geddie / Executor 501 S. Parke Street, Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 9/28/09 West Chester, PA R.A.Ferris & Comp. 22. Name and Address of Facility
Tarring—Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 23a. art1. Enter the 1 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death disease or condition resulting in death) MATOR DEPRESSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: The

the burial-trar s after dec. completely filled in by

Physician/Medical

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Completed

Be

Certification: To

Medical

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

in than "natural", or items 23a or 28a-f show the Medical Examilian roust be notified at

Director

Completed by Funeral

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21215-0036

Baltimore, Maryland

RNOWN

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked, any lijury or other traumatic evone.

**Physician** 

/Medical

Examiner

To the Hospital o within 24 hours af To the Funeral Di State

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. SEPTEMBERAG, 2009

052739 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), LURESH SHANDELYA, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MOLIGOR 32. Registrar's Signature

31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** AM 1143 FRANK LANCE SEPTEMBER 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS BAYVIEW BAUTIMORE CITY MEDILAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Aug. 13, 1945 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** MD (Country) 1 → M 2 □ F Months 212-44-4784 64 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If the Medical Examinar must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD Baltimore 1 ☐Yes 2 ☐ No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4308 Plainfield Ave. 21206 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. Completed by Specify Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Handyman Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Lance Luella Davis ٥ 19a Informant's Name/Relationship (Type. Print) William Lance, Sr. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
OB Plainfield Ave. Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crematory 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/21/09 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 2007-09 Eastern Ave. Baltimore, MD 21231 21. Signature of Funeral Service Licens 23a, Part 1, Enter the disease, recations that caused the death one cause on each line. onter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or shock, or heart failure. Liston Immediate Cause (Final disease or condition resulting in death) **Physician** MULTI-ORGAN FAILURE /Medical Due to (or as a consequence of): **Examiner** WEEKS STAPH AUREUS BACTEREMIT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by cate has been significated be a 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 X No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 29a. Certifier 📜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-009 DEPTEMBER MEDICAL DOCTOR 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PSSIS

State Registrar JUST IN

31. Date filed (Month, Day, Year)

CHRONISTER

Darke

JOHN'S HOPKINS BAYVIEW MEDICAL CENTER

Registrar's Signature

4940 EASTERN AVENUE

BALTIMORE MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Lillian **Physician** 09:50 PM 2009 4 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Rehabilitation Extended Care Birthplace (State or Foreign Country)
 New York 8. Date of Birth (Month, Day, Year)
May 18, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 □ M 2 🖾 F Months Davs 80 Yrs. 1929 Director 074-22-4748 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State or other traumatic event, the Wedical Examiner must be notified at 1 ☐ Yes 2 🗖 No Funeral Director Baltimore White Hall Maryland 10g. Citizen of What Country? 10e. Street and Number 21161 USA 2203 Elliotts Chance Court 12. Was Decedent Ever in U.S. Armed Forces?

1 Wes 2 No 1958 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1X Never Marrled 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify. Completed by Specify: White 3 Widowed 4 Divorced 1964 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chemical Engineer U.S. Airforce 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Leonard ည John H. McNally 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 Turnstone Circle Greensboro, NC 27455 Kathleen McNally, Niece 20c. Location - City or Town, State Pages 1 ament of He 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If its any Injury or o 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 09/25/09 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Parkinson disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) ipital or Attending Physician: The law requires that the death certificate be executed usurs after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Vear 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 | Yes 2 → No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **N**o 1 □Yes 2 11No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 09/24/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) X Baltimore MD 21218 00 Loch Raven MROWIEC 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Both **Physician** DWARD 07.45 AM SEPT 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 218-42-9569 1**™**M 2□F PARYLANI Director 07/07/194 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the "Actical Examination of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the profile of the prof 1 XYes 2 No Director BALTIMORE MARYLAND 10e. Street and Number 10g. Citizen of What Country? EDGELUDOD 4052 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 MYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DRIVER MIF 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MOSIEY JAMES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau (WIFE) 4052 Edgewood Rd., Baltimore, MD 21215 LAUREN MOSLEY 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 🗷 Burial 2 🗆 Cremation 3 🗔 Removal from State 10/5/2009 CLYINGS MILLS, MARYLAND CARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) ervice Licensee 22. Name and Address of Facility 5R. FUNERAL HOME 5058 PH H. BROLON 5R. FUNERAL HOME 5058 PH H. BROLON 5R. FUNERAL HOME 5058 PH H. BROLON 5R. FUNERAL HOME 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner JRINARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☑ No Ö 9 ☐ Unknown signed by to <u>ت</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by DISSEMINATED INTRAVASCULAR COAGULATION 2 No 3 Probably 4 Unknown been si should t 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No ADENO CARCINOMA OF ESOPHAGUS WITH 24a. Was an page 2 s certificate METASTASIS TO LIVER & SPINE 1 □ Yes of Vital r this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To : After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending . 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

6+1 State

31. Date filed (Month, Day, Year)

29b. Signature and

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DV SAYED KAZI SEOI LOCH RAVEN BLVD BALTIMONE

M.D.

SED 29 2010

title of certifie

Registrar

29c. License number

Res 000.

29d. Date signed (Month, Day, Year)

MD

2009

For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** nthon Monatoli 162001 0502A 07 /Medical 4b. City, Jawn, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Br Hima 04 Mari Universit lan 8. Date of Birth Ov 04 1986 place (State or Foreign Month, Day, Year, 1998) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 ★ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 22 Hours 063-72-6461 New York Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show other traumatic event, the Medical Expresser must be notified at 1 ☐ Yes 2 X No Director Harford Abingdon Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō "natural", or items 23a 21009 U.S.A. 744 Shallow Ridge Court Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No Black, White, etc. Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White If Yes, Give Year or Dates: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Store 12 Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elda Borrelli ၉ David Mastronardi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other tra once. 307 Murphy Avenue, Endicott, New York13760 David Mastronardi 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Twin Tiers Cremation Services 9-22-09 Endicott, New York 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 21214 21. Signature of Funeral Service Licensee Mar 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** The mat disease or condition resulting in death) rain /Medical Due to (or as a consequence of): Examiner Secondar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of). Box 68760, Physician/Medical OCME IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2☐No by the o 9 Unknown σ. þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2 □No 1 ☐ Yes 2 ☐ Ao Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) this c Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1374 M 1 ☐ Naturai 2 ☐ Accident 3 ☐ Suicide 5 Pending investigation Sept 1/1 2009 1 ☐ Yes after death Director: 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 301 Guilford Avenue 4 Homicide n 24 hour the Funeral Dire Bar Baltimore MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) within 2. and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rom A. Stevens, University of Maryland Hospital, 22 S. Greene Street, Balto., MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month MBER Pay 22 Year 70 6:4EF M Angus Masters, Jr. 4c. County of Death Haltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Center Saint Joseph Medical Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1**X** M 2□ F 9/12/1932 NC 240-46-2760 77 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Carrol1 Westminster 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21157 USA 3401 Mail Rd. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 21 Married 1 ☐ Yes 2X No 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: 1955-61 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Enterprise Electric 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Blanche Robinson Angus Masters, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3401 Mail Rd., Westminster, MD 21157 Jean Masters/Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem. Gardens 9/28/2009 Marriottsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burrier-Uueen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YEARS Immediate Cause (Final CARDIOMYOPATHY disease or condition resulting in death) Due to (or as a consequence of): VALVE REGURGITATION YEARS SEVERE MITRAL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown STATUS POST MITRAL AND AORTIC VALVE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an REPLACEMENT SURGERY autopsy performed?

**Physician** /Medical Examiner Physician/Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner dust be notified at

"natural",

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rany injury or other traumatic event, the Med once.

Director

Funeral

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Completed

Be

2

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the burial-tran physician use as I signed by the a To the Hospital or Attending Physiclan: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

þ

Completed

Be

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

HYPERTENSION	AND CARDIAC ARRHYTHMI	A 1Xiyes 2□No 1Xiyes 2□No									
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner? 1 <b>X</b> Yes 2 □ No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DO	A Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)									
27. Manner of Death  1 Natural 2 Accident  5 Pending investigation	(Month, Day, Year) Injury	3c. Injury at Work? 1 □ Yes 2 □ No									
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
On Contillar 4 M Constitution Dt		the time date and place and due to the equac(a) and manner as stated									

Medical Certification: To (Check only one) 29b. Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

D34543

09-23-0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRIVE TOWSON. MARYLAND 21204 7601 OSLER STEVEN R AXE Registrar's Signature 31. Date filed (Moeth, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 21 **Physician** Michelle Myerly 2009 Sep 4:27A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 25 Pelczar Ave. Essex Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days Hours 1 □ M 2 □ F 175-52-2288 Jan.19 41 1968 MD **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 25 Pelczar Ave. 21221 USA Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify. Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Clarence Myerly Betty Kirkpatrick ၉ and l 19a. Informant's Name/Relationship (Type. Print)
June Wilson (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Pelczar Ave, Essex, MD 21221 of Health a Injury or other Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If it any Injury or once. 09/21/09 Hanover, MD Ardent Cermatory 22. Name and Address of Facility Wesley Chavis, JR. Fnrl. Hm 21. Signature of Funeral Service Licenses 2007-09 Eastern Ave., Baltimore, MD 21231 23a, Part 1. Enter the disea seused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or complications that List only one cause of shock, or heart failud Immediate Cause (Fina disease or condition resulting in death) **Physician** NONSHALL LUNG CANCE MONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as a consequence of burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Yes 2€No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, after death

filled in by within 24 hours a

To the Funeral completely

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DOC58475

PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEPT [ N BIT ~ 23, 2009

9114 PHELADELPHEA ROAD, 8 ALTEMONE MD 2123 PHELIPNINATONEN 31. Date filed (Month, Day, Year)

Registrar

Medical

SFP 29 2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day September 21, **Physician** 2009 Α. Clarence Moore 2:55p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carrol1 Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday, **Funeral** Min. 1 3 M 2 □ F Months Days Hours Director 214-14-1585 86 August 5,1923 Illinois Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2x No Director MD Baltimore Reisterstown death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 102 Nob Hill Drive 21136 Funeral U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~ "... any liqury or other traumatic evere. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 I If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐Yes 2 No Specify þ Specify: 3 ₩ Widowed 4 Divorced WWII White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) C & P Telephone Co. District Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Bedford Li1a Moore Monet 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 Kathleen M. Rittler Daughter Reisterstown, MD 3413 Buttonwood Court 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Evergreen Mem. Gardens 9/28/09 Finksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road m Reisterstown, MD 21136 ELINE FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Bi neum Dria **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner rdis high Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ disease 5 m 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1NO 1 □Yes 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) East hain St. Westwinster MA 21157 MA S 11 32. R gistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Registrar

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DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CUILLERMO JOSE, CIAN EDECO

31. Date filed (Month, Day, Year)

D0085+14

301 HOSPITAL DRIVE, GLEH BURNIE, MD 20161

SEPTEMBERZY, 2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 200 /Medical 4a. Facility Name (If not institution, give street, and number) Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number (In yrs. last birthday **Funeral** Days 1 M 2 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 □Yes 2 ☑No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than "any Injury or other trainmeting." Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Print) 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Num r. City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) Date Location - City or Town, State 1 ☐ Burial 2 Cremation 3 Removal from State → Other (Specify) 4 □ Donation 21. Signature of 23a. Part Univ. the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a cert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cruse (Final disease or condition resulting in death) **Physician** TERMINAL LUNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the l IF FEMALE: nse ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy perform 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Nother Specify itospice Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 5 Residence 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No after death filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 30. Name and address, of person who completed cause of death (Item 23a) (Type, Print) 540 31. Date filed (Month) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 22, 2009 6:30 P William Moore Audrey September /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Co. Dundalk 1738 Stokesley Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 🖳 M 2 🗆 F Yrs. Director 213-20-5109 Usual Residence of Decedent 5,1925 Maryland Oct. 83 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylai nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f shov Lry or other traumatic event, Ite Medical Examirer must be retiffed at 1 Yes 2FXNo Director Dunda1k Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1738 Stokesley Road United States Funeral 21222 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyes 2 No
If Yes, Give
Year or Dates: 1943–45 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No þ Specify: White 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Steel Worker 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice E. Kelly ဥ William A. Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 1818 Glen Cove Road P.O. Box 67 Darlington, 19a. Informant's Name/Relationship (Type. Print) Joann Shortridge (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I Important: If its any Injury or o 1 ☐ Burial 2 TxCremation 3 ☐ Removal from State Hilltop Service Corp: 9/25/2009 Towson, Maryland 4 □ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate eause. Enter the charge Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ed by the a 1 □Yes 2 □ No. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DIABLIES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed' certificate ANEMIP 2 No 1 ☐ Yes 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation ours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records,

P.O. |

State Registrar

within 24 hours a

29a. Certifier

29b. Signature

KISHORIE

Medical

WRITH PT.

and manner stated.

9600 32. Registrar's S. mature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year NGTON :52 PM 2009 26 4a. Facility Name (If not Institution, give street and number) Town, or Location of Death 4c. County of Death Belliner Medical Cecter If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Min. 45 Months Days Hours 218-94-1822 Aug. 4,1964 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 21 No Anne Arundel Severn 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 925 Merriweather Way 21144 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Training Specialist Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bobby Stickley Nettie Ellen Isaacs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Ron Mellington/Husband 925 Merriweather Way Severn MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 4□Donation 5型Other (Specify)Entombment Hillcrest Mem.Garden Annapolis, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Cention Gear disease or condition resulting in death) Due to (or as a consequence of): SCUSUO to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 1 ☐ Yes 2 □No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 12 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

/Medical Examiner The law requires that the death certificate be executed Box 68760€ P.0. Division of Vital Records. certificate Physician: After this

attending physician and for use as the burial-transit signed by the a been si cate has I page 2 s funeral director, filled in by

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Eventine must be nutified at once.

**Physician** 

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be

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Examine

MD

Physician/Medical ð Completed Be or Attending s after deam.
raf Director: After within 24 hours a To the Funeral D Hospital

မ 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 8 nd address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, 1 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b-c, perFH, G896, 10/6/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year TEMBER 28, 2009 Physician 24:21AM Yun Ma Qiao /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical Center Baltimore Joseph OWSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 💢 F 12-30-1928 Director China 126-78-5556 80 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Eval, it with ust be notified at 1 ☐ Yes 2 XNo Director Baltimore Towson Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 Completed by Funeral 600 Squires U.S.A. Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify. 3 X Widowed 4 ☐ Divorced Chinese 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Ophthalmologist</u> <u>Medicine</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked 1 any injury or other traumatic evo ပ Shi An Lin Fang 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> 21286</u> <u>600 Squires Road</u> Towson, Maryland Yuai Wong Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date the 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. 12,2009 Valhalla, New York **Kensico Cemetery** 21. Signature of Funeral Service L 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Jan 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complex tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE AORTIC DISSECTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🛚 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 
Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 KHOSROW TABASSI. OSLER DRIVE M. D. 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 7 30 AM 23 200 uth and 1 515 21093 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Boltimere Peresis Lutherville MD Bright Field ou 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Min 231-34-704 1 □ M 2 🗽 -13-193 VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No MD. N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 USA 5440 NELSON AVE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify. Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -12-HOUSEKEEPING DOMESTIC -0-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VIOLA G. VENEY RICHARD JORDAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104319a. Informant's Name/Relationship (Type. Print) SHERMAN POPE(SON) 5442 AUTUMNFIELD PORT ELLICOTT CITY, MARYLAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other 3 Removal from State 5 ☐ Other (Specify) DRUID RIDGE CEMETERY 9-29-2009 BALTIMORE, MARYLAND 21. Signature of Juneal Service License-JONATHAND. HIBNER 22. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End Svoge demente End Sv Oge Due to (or as a consequence of): ueans Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4. Donknown

**Physician** /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show a

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r than "natural", or items 23a or the Medical Examiner must be

death with the Maryland

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If Item 27 is marked other 1 any injury or other traumatic event, the

Saltimore, Maryland 21215-0036

death certificate be executed and burial-trai physician Box 68760 the attending nse ρ P.0. ed by the a detached f Division or Vital Records, peen

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Registrar

To the Hospital or Attending within 24 hours after death. To the Funeral Director: After

Examiner Physician/Medical þ Completed Be

page 2 s Certification: To funeral the

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

24a. Was an autopsy performed? 2010 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

Injury

27. Manner of Death 5 ☐ Pending investigation Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

4 Homicide

29a. Certifier

29c. License number 00053150 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Supre

Suple 9600 sanhayo kd Shakunmale

31. Date filed (Month, Day, Year) SEP 29 2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#3perPHYS G896 10/19/09 WS
State of Maryland / Department of Health and Mental Hygiene

			1 = For State State Registrar		ertificate of			g. No.	9 9 1 1 4 7
	Phy	nician	1. Decedent's Name (First, Middle, Last)				Date of Death     Month	Day Year	3. Time of Death 7:50 AM
		sician edical	Catherine Antoinette Nipwoda				Septembe	er 25, 200	09 <del>7:50 P </del>
	Exa	miner	4a. Facility Name (If not institution, give street and number)			or Location of Death		4c. County of Dea	
	الاستيال المراجع		Upper Chesapeake Medical Cent  5. Social Security Number 6. Sex 7. Age (In yra	er s. last birthday	Bel Air		8. Date of Birth	Harford	rthplace (State or Foreign
	Fune Direc		214-22-6246  Usual Residence of Decedent    Sex   1	Vrc	Months Days	Hours Min.	Month, Day,  July 17	Year) C	aryland
	laryland show	, i	10a. State 10b. County 10c. C	City, Town or L	ocation	-			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M 28a-f	ectc	Maryland Harford B	el Air	10f. Zip Code		10	g. Citizen of What C	
0350	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show the frantes and the Marical Forming must be notified at	Funeral Director	612 Beretta Way		21015			USA	
工	er de. Items	l en	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S.   13	. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Ricaп, etc.)	14. Race - Am Black, Wh	
	ours after	Completed by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates:		1⊡Yes 2⁄2 No				Mhite
TOD 215-003	72 h matu	ete	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occup e kind of work done	pation during most of workind)	ng 1	6b. Kind of Business	s/Industry
1- E	within sne.	Ę	Elementary/Secondary (0-12) College (1-4or 5+)		1 Service			U.S. Gove	rnment
2	Hygir E	္မွ	17. Father's Name ( <i>First, Middle, Last</i> )	02.02		18. Mother's Name	(First, Middle, M	laiden Surname)	
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	1 and 2 Health a		Mary Ann Becker / Daughter	770	07 Baggin	s Road, Ha	nover, N	Maryland,	21076
125	est test		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	. Place of Disp cemetery, cr	oosition (Name of ematory or other pla	nce)	ate 2	20c. Location - City o	r Town, State
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9125/ Raltimore	permit. Pages Department of Important: If i	once	21. Sign turl of Fineral Service Licensee		22. Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Address Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name and Name a	ess of Facility Mc adway, Bel		uneral Hon aryland 21	•
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3 1	ician ician certifi	Be	25. Was case referred to medical examiner?	. /	l Ott	26. Place of Death	(Check only one	9)	
7 1	Phys	<u>은</u>	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury	28b. Time	SIIL SU DOA	4 LI Nursing Ho		nce 6 □Other (Sp w injury occurred	pecify)
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2	tal or safte	Certification:	building, etc. (open					, olale)	
Nipwada	To the Funeral Director: After this certificate his	Medical	29a. Certifier (Check only one)  1☐ Certifying Physician: To the best of my k 2 ☐ Medical Examiner: On the basis of examiner and manner stated.						
E	To th	Me	29b. Signature and title of certifier		29c. Licen			d. Date signed (Mo.	
	}		S. Doesnow. Wo		DO	0023£36	) E	B1921 5	<del>Jesse</del>
			30. Name and address of person who completed cause of death (It	ale wh	acero	19 # 10 F	Bek	zeir, W	ש אפוני.
	Red	State jistrar	31. Date filed (Month, Day, Year) SEP 2 9 2009	gnature	weil				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26, Physician Month 2009 Patricia Sept. 10:25AM Overstreet /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FutureCare Sandtown/Winchester Baltimore 8. Date of Birth (Month, Day, Year) 08 - 24 - 24 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2XX Months Days Hours Director 85 NC 228-68-8820 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD NA Baltimore XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 N. Gilmor Street 21217 USA Funeral 14. Race - American Indian, Black, White, etc. African 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: þ Specify: American 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 11th Grade College (1-4or 5+) Domestic Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lonnie E. Paston Lela Wilson ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Maggie V. Lighty-Sister 5319 Snowden Lane Richmond, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 09-29-09 | Catonsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Rome P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HE ART GALURE Due to (or as a consequence of): CIMEDIVIE OBSTRUCTIVE PULTINAR 7 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine REVAL INSUCFICIENCY Due to (or as a consequence of): dical LIMPERTENSION 23d. Date of delivery Month Year Day use contribute to the cause of death? □ No 3 Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 ☐ Other (Specify) ry occurred nd Number or Rural Route Number,

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Baltimore, Maryland 21215-0036

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Physician/Me	IF FEMALE:  23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	23d. Date of delivery Month Day Yo
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rification:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of lnjury  M   28c. Injury at Work?  1   Yes 2   No	3d. Describe how injury occurred
Certific	3 ☐ Suicide 6 ☐ Could not be determined		3f. Location (Street and Number or Rural Route Numb City or Town, State)
dical	29a. Certifier (Check only one)  Certifying P  Certifying P  Medical Exa	nysician: To the best of my knowledge, death occurred at the time, date and place, a míner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)

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32. Registraris Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAMINDA

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State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 29 2009

JAMO

29c. License number

punite

DOV 56948

3 4

29d. Date signed (Month, Day, Year) 28 14

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no

BALTMORE

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First: Middle, Last) 2. Date of Death 3. Time of Death **Physician** september 27 200 mic /Medical 4a. Facility Name (If not institution give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner KAM RIEN (Wite Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Year) Months Days Hours Min 1 ☐ M 2 🖫 F Director 371-54-2194 5/28/1931 78 Japan Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov adiesi Examiner must be notified at Yes 2 □ No Director Maryland Harford Aberdeen 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code hours after death with 3803 Aldino Road 21001 USA Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐Yes 2 ☑ No Specify: Specify: Oriental 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry filed within 72 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mede once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housewife 12 in home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Kurosaka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred Ott (son) 415 Truman Ave., Lehigh Acres, FL 33972 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) R.A.Ferris & Comp. 9/28/09 West Chester, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carelion PV/mmy /Medical Due to (or as a consequence of): Examiner rehrovaralan Se unitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): led by the attending physician and detached for use as the burial-tran resulting in death) Last P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No. 9 Unknown signed by the detachε Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 No After this certificate 2 No 1 □ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Denursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA nours after death.

neral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide Hospital e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) within 2 and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mn 101 31. Date filed (Month, Day, Year) . Registrar's Signature SEP 29 2009 Registrar

Please Type or Print in Black Indelible Ink 577 His Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Nicholle Pinkney Tamika SEPTEMBER 25 2009 4:55 A 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 9. Birthplace (State or Foreign Country:Land If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day V 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Days 1979 Hours 1 □ M 2√□ F 215-94-0406 29 Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Gwynn Oak Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21207 6505 Liberty Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Premier Windows& Office Assistant 12th grade Building 18. Mother's Name (First, Middle, Maiden Surname)
Tamara Lindsay 17. Father's Name (First, Middle, Last) Earlston F. Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamara Harris/ Mother Harold L. Pinkney, Jr.-Husband 6505 Liberty Road Gwynn Oak, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Arbutus Memorial Park 1 Burial 2 Cremation 3 Removal from State Arbutus, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facilit Chatman-Harris Funeral Home 21. Signature of Funeral Service License 5240 Reisterstown Rd Baltimore, MD 21215 Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

**Physician** /Medical Examiner burial-trar Division of Vital Records, P.O. Box 68760, physician the attending p for use as 1 cate has been signed page 2 should be det To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director Director;

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Director

by Funeral

Be

Examine

Physician/Medical

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Completed

Be

Certification: To

(Check only one)

29b. Signature and title of certifier

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the Once.

21215-0036

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO057177

29d. Date signed (Month, Day, Year)

MID

SEP 25, 2009

21131

09-07471

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Donna Plummer		I- For State	laryland / Department o <i>Certificate</i> o		II Hygiene Reg.	No.	19 3115
Physici	an/	Registrar  1. Decedent's Name (First, Middle,Last)			2. Date of Death Month	Day Year	3. Time of Death 1445 hrs
Medical Exami	ner	Donna Elaine Plumme  4a. Facility Name (if not institution, give stree		4b. City, Town, or Location of D	Month September	24, 2009 4c. County of Death	1445185
)		1419 Mullikin Court	and numbery	Baltimore			
Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours	24Hrs. 8. Date of Birth Min. 05/25/1	(MM/DD/YYYY) 9. Birti Foreigi Cou	hplace (State or IntryMaryland
Å		Usual Residence of Decedent	10c. City, Town or Loc	otion			10d. Inside City Limits
he Maryland or 28a-f show any fied at once.		10a. State 10b. County	Baltimor				1 X Yes 2 No
larylan 18a-f st at onc	Director	10e. Street and Number		10f. Zip Code	109	. Citizen of What Coun	itry?
imore, MD 21215-0036  Pages I and 2 should be filed wittin 72 hours after death with the Maryland ment of Health and Mental Hygeine. It litem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		1419 Mullikin Cour		21231		U.S.A.	Disch
ath wit	Funeral	1 Never Married 2 Married	rmed Forces?	Nas Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, F	n? ( Specify Yes or No- Puerto Rican, etc.)	White, etc.	can Indian, Black,
fter de I", or i		3 Widowed 4 X Divorced If Yes,	Yes 2 X No Give Yaar	Yes 2X No specify:		Specify: B1	ack
hours a natura Exami	ed by	15. Decedent's Education (Specify only high	during	lent's Usual Occupation (Give kir most of working life. DO NOT us		16b. Kind of Business/I	ndustry
36 hin 72 e. than "	Completed	Elementary/Secondary (0-12) C	ollege (1-4 or 5+)	ırse	ļ	Healthcare	
21215-0036  uild be filed within 72 hours after Indental Hygiene. marked other than "natural", ic event, the Medical Examiner		17. Father's Name (First, Middle, Last)		18.Mother's	Name (First, Middle, Ma	aiden Surname)	
121 Id be fi Aental Inarked	o Be	Hezekiah Clark  19a. Informant's Name/Relationship (Type, P	rint ) 19b. Mai	ling Address (Street and Numb	ores Steves er or Rural Route Numb		, Zip Code) 20772
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Elygiene. Important: If tiem 27 is marked other than injury or other traumatic event, the Medic	F	Kyra Thompson/Daugh		0615 Elizabeth	Parnom PL.U	Jpper Marlb	oro, MD
re, f s 1 and f Healt If item		20a. Method of Disposition  1 Burial 2 X Cremation 3 Re	20b. Place of Disp	oosition (Name of cemetery, other place)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of Hee Important: If ite		4 Donation 5 Other Specify:	Andent Cr	emation Services (	09/29/2009	Hanover, M	laryland
Ball permit Depart Impor	7 8	21. Signature of Funeral Service Licensee Zaura C. Hardesty		2. Name and Address of Facility 7522 Connelley			
Physician		23a. Part I. Enter the disease, or complication failure. List only one cause on each line	ns that caused the death. Do not ente	er the mode of dying, such as car	rdiac or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
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Box 68760, e death certificate be the attending physic ed for use as the bur	cian/	23b. Was decedent pregnant in the past 12 months?	Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic	pregnancy	Month	Day Year
). Box the death by the atte	Physician/	1 Yes 2 No 9 Unknown 9	Unknown		A.L. 220 Did tob	pacco use contribute to	the cause of death?
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Division of Vital Records, P.O pital or Attending Physician: The law requires that tours after death.  reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detaa	₽	1 ✔ Yes 2 No	8a. Date of Injury 28b. Time			Residence 6 Othe	er: Scene
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To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On t	to the best of my knowledge, death of the basis of examination and/or invest	ccurred at the time, date and place tigation, in my opinion, death occ	curred at the time, date a	and place, and due to t	he cause(s)
or pand is a s	Me	29b. Signature and title of certifier	manner stated.	29c. License number		29d. Date signed (Mo	
		Will I	()ND	O.C.M.E.		September 25, 2	2009
ØJ		30. Name and address of person who composite Russell Alexander MD. Assi		11 Penn Street, Baltimo	re, MD 21201		
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1			
Regi	strai	SEP 2 9 200	y Clinson G.	Bake			<del> </del>

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept.26, Year 2009 **Physician** 2 P.M. M Elizabeth Perkins Susan /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Reisterstown Baltimore 100 Neel Ave 8. Date of Birth (Month, Day, Year) Sept 25,1961 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 □ F Baltimore, Md. 215-88-9998 48 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, he would be an instruction and the result of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the sec 1 □Yes & □No Director Baltimore Reisterstown Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21136 USA 100 Neel Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married White 1 □Yes 2 No Saltimore, Maryland 21215-0036 Specify. Specify à 3 ☐ Widowed 4 🕅 Xivorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Retail Automotive High School

17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JoAnn Gingrich ဂ္ဂ J. Harvey Raver Jr. bepartment of Health and N. Important: If item 27 is many Injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. JoAnn G. Raver 100 Neel Ave. Reisterstown, Md. 21136 (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) All Saints Cemetery Sept.30,09 Reisterstown, Md. 21136 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road Eline Funeral Home Reisterstown, Md.21136 23a Part 1. Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

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Carticly Cartiers of Cartiers (Final Cartiers or Cartiers). Approximate Interval Between Onset and Death **Physician** resulting in death) /Medical Lue to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events Due to for es a nomecuança difinding physician and use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy been signed by the atte should be detached for Month Year 4 Pregnant at time of death 9 Unknown 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use ontribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ₽ No 1 □ Yes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 2 [ 2 🗀 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 5 Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 2 □ Accident 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 29a. Certifier 🗑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier signed (Month, Day, Year) 30 Name and address of person who complet of death (Item 23a) (Type, Print) Yousht bottox Duth Cate 31. Date filed (Month, Day, Year 32. Redistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#23a, ptlperPHYS, G895, 9/29/09, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month Rose 812 AM Physician Paparelli 09 12 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Balhacre Franklin Journ Ballinor Hospital Cenker If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2 F 85 Director 217-20-0016 May 8, 1924 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

1. Sand 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be retified at **Baltimore** Parkville 1 ☐ Yes 2 ☐XNo MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8810 Walther Blvd. Apt. 1413 21234 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry **MoCormick** Elementary/Secondary (0-12) College (1-4or 5+) Clerical Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Papa Armando Paparelli ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36094 Beaver Dam Rd. Frankford, Delaware 19945 William Pierro/Nephew Department of Healt Important: If item 2 any Injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Recemer Caretery 20c. Location - City or Town, State Date Pages 1 tment of H 20a. Method of Disposition 🏋 Burial 2 🗆 Cremation 3 🗆 Removal from State 09/25/09 Baltimore, MD 4 Donation 5 ☐ Other (Specify) atuge of Funeral Service 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkvi lle, MD 21234 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, school, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death me ate Cause (Final **Physician** ardiopulmonary disease or condition re using in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed Sepsis and the buriat-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☑ No 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day, Year) 27. Man er of Death filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 9/28/09 Kes00000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gowlman 9000 Frendly Square 2/23-Adam 0-31. Date filed (Month, Day, Year) SEP 2 9 2009 32. Registrar's Signatu State Registrar

Aporelli

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** PEACOCIC, SR 1:35 PM RICHARD SEPTEMBER 22 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE RUXTUN TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Funeral Months Davs Hours Min. 1 X M 2 □ F 29 215-24-6175 Maryland 81 Jan Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City Town or Location show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2K No Director 28a-f Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 'natural", or items 23a 21220 USA 12902 Harewood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 □Yes 2 🗓 No Specify. þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 02 U.S. Government Carpenter s 1 and 2 should be filed voil Health and Mental Hygicitem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Preston Peacock Beulah Elizabeth Fowler ပ Theodore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Gayle-Peacock/Daughter 12902 Harewood Road, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Pages 1 permit. Pages 1 Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 9/28/09 Glen Burnie, Maryland 21. Sindire of Fine 200 relicensed Bryan W. Clary 22. Name and Address of Facility
Lemmon_Funeral_Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 23a. Part 1. Enter the disease, or complications that caused the shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** PEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed /sician and Due to (or as a consequence of) ng physician a Completed by Physician/Medical attending p Box ( IF FEMALE: nse 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö the 9 Unknown 9 Unknown signed by be detach σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, STAGE IN DECUBITUS ULCER OF SACRUM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 CHO of Vital 1 ☐ Yes the Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA hours after death.

Ineral Director: After this villed in by the funeral di Medical Certification: To 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar LEUNARD

31. Date filed (Month, Day, Year)

SEP 29 2009

D57722

M.D. 1838 GREENE TREE ROAD # 300 PILLESVILLE MD 21208

SEPTEMBER 25 2009

M-D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARDSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3 Time of Death Dav **Physician** 10:50 AM Pilone, Jr. Vincent Joseph 20. 2009 /Medical Sent 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 347 Fullerton Place Abingdon If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Date of Birth (Month, Day, Year, Months Hours Days Min. 1 🔀 M 2 🗆 F Sept. 16,1945 Director 214-44-3937 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f shore 1 ☐ Yes 2√∑ No Director Abingdon Harford Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 ages injury or other traumatic event, the Middle France Liust bears once. United States 21009 347 Fullerton Place Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 👿 No Specify Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Manufacturing Joseph A. Banks 11 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Cammarata Joseph Vincent Pilone, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 1911 West Lombard Street Baltimore, MD 21223 19a. Informant's Name/Relationship (Type. Print) 1911 West Lombard Street Mr. Gerald Pilone, Sr. (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 9/24/2009 Baltimore, Maryland Donation 5 ☐ Other (Specify) 21. Signatu of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222 7922 Wise Ave. Dundalk, MD Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RECOR **Physician** 1ETASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): spital or Attending Physician. The law requires that the death certificate be executed ours after death.

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first and by the attending physician and filled in by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burta-transit Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Was a. autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 2 🗆 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospital **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

UNIVERSITY

31. Date filed (Month, Day, Year)

**ORIGINAL** 

MYSICIAN

21.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAND

32. Registrar's Signature

OF

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Green

D5066107

29d. Date signed (Month. Day, Year)

PANDYA, MO

MEMISON 22

# Physicia /Medica Examine Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninar must be notified at once. Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

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ř	19a. Informant's Name/Re		-	111	19b. Mailii	ng Address (Street					. State. Ziu	D Code)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 12:20P M 76 2003 frauda ( aske /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner FutureCare-Canton Harbor Baltimore City
Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗗 F Hours Min. Days 219-05-8536 88 Months Maryland 02.23-192 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b, County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the McAlon Examinar must be mailined at 1X Yes 2 □ No **Funeral Director** Md. Baltimore City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 1229 Delbert Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: Completed by Specify: 3 ₩ Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Je, Maryla Lermit. Pages 1 and 2 should be be Department of Health and Mer-Important: If item 27 in any injury or cer. of Health and Mental item 27 is marked o Pearl Punte John Ruth ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5151 Michael Pasko - Son Terrace Drive Nottingham, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-30-2009Baltimore, Maryland <u>Gardens</u> of Faith 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses Robert 1201 Dundalk Avenue Baltimore, Md.21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Hyperturious Artauschutic Correg Vopenen Disease Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Daw to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav Month 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Carelio Medica social end 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Deneuha 24a. Was an has autopsy performed? Wateres this certificate 2 110 1 ☐ Yes 2 ☐ No 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□Yes a□No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? After or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D19667 09-27-2009 (washing) L'Ilucal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

Geo Barner Haugland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 VIGn /Medical **Examiner** Baltimore Center Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours 1 □ M 2 F Months Days Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. m 27 Is marked other than "natural", or items 23a or 28a-f show 10h. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and the confiled at once. 1XYes 2 □ No Funeral Director 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ► No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Iack. Completed by Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Be ပ Ope. Print brother or Rural Route Number, City of Town, State, Zip AKE 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) Funeral Service Licemsee . Part 1. Enter the diseas shock, or heart failure. disease, or complications that caused the death. Approximate Interval Between Onset and Death imediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify). P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □No 2 100 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 1 N Certification: To 1 ☐ Inpatient 2 ☐ ☐ ☐ Outpatient 3 ☐ DOA 4 \Bursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct
completely filled in by 4 Homicide Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar

401

31. Date filed (Month, Day, Year)

32. Resistrar's Signature

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			State of Mary				lental Hygi	ene	
			Registrar  1. Decedent's Name (First, Middle, Last)	Cei	rtificate of L	Jeath	2. Date of Death	g. No.	3 Time of Death
	Physicia		Linda Staley Ritchey					er 24,0 ^{Year}	9;00 P/M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	
-2			Dove House		Westmi	nster If Under 24 Hrs.	9 Data of Birth		roll hplace (State or Foreign
	Funeral Director		5. Social Security Number   6. Sex   7. Age (Ir 214-34-2872   1 □ M 2 1	n yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Nov. 19,	Year) 1936 Free	derick, Md.
	ס		Usual Residence of Decedent						10d. Inside City Limits
	arylar show	ō	Md Carroll	c. City, Town or Lo.  Hamp	stead				1 ☐ Yes 2 No
	the M 28a-f	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?
	h with	alDi	4293 Wolf Hill Drive		2107	4		USA	
	should be filed within 72 hours after death with the Maryland and Mental Hygiene.  marked other than "natural" or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Funeral	11. Marital Status  12. Was Decedent Ever Armed Forces?  1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☒ No	r in U.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
39	ırs afte I", or i Xamir	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:	,	1∐Yes 2X∏No	Specify:		Specify:	White
2-0	72 hou		15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation during most of work		6b. Kind of Business/	Industry
21	ithin 7 ne. han "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. I	DO NOT use retired	) -	9	Own Hom	
d 2	filed within 72 Hygiene. Ither than "nai ent, the Medic		2 Yrs. Coll 17. Father's Name (First, Middle, Last)	ege	Housewit		e (First, Middle, M		le
an	lld be fental rked o	To Be	Oscar L. Staley			Courtn	ey A. Ho	oper	
Maryland 21215-0036	es 1 and 2 should be of Health and Mental (Item 27 Is marked or other traumatic ev		19a. Informant's Name/Relationship (Type. Print)					City or Town, State, 2 ad, Md. 21	
	l and land land land land land land land		Wylie L. Ritchey Jr. (Husband 20a. Method of Disposition	20b. Place of Dispo				Oc. Location - City or	
nor	Pages nent of h int: if ite		1XXSurial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer All Saint	natory or other plac	e) ;		Reisterst	
Baltimore,	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	22	2. Name and Addres	ss of Facility	11824 1	Reistersto	
20	8 2 E 8 9		Samb Sline		line Fune		Reiste	rstown, Md	Approximate
		(	23a. art 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.		or the mode of dying				Interval Between Onset and Death
-	Physician /Medical		disease or condition resulting in death)  Due to (or as a co		JUNG	YTTE	- (We	4^	
	Examiner		Sequentially list conditions b.						
	ed sit	Jiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	onsequence of)					
	cate be executed physician and the burial-transit	Examiner	that initiated events c	onsequence of):		· · · · · · · · · · · · · · · · · · ·			17
8760,	ate be nysicia ne buri	dical	d						
89 X	ertifica ting ph e as th	Med	IF FEMALE:						
Box	eath certific attending p for use as	cian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of part 1 □ Live birth 2 □ Pregnant at time	Fetal death 3	☐ Ectopic pregnanc☐ Other (specify) _	у		23d. Date of de Month	livery Day Year
P. O.	that the de ned by the detached	Physician/Me	1 Yes 2 No 9 Unknown						
S,	es tha iigned be det	ğ	Part II. Other significant conditions contributing to death but n	not resulting in the u	nderlying cause giv	en in Part I.		acco use contribute to	
o D	w require been si should b	eted							robably 4 Unknown
Records,	ne faw e has b ge 2 s	Completed			<u> </u>		24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
Vital	Physician: The la r this certificate ha ral director, page 2		25. Was case referred to medical			26. Place of Deat	1 ☐ Yes 2 th (Check only one		s 2 □No
<u> </u>	nysick nis cer direct	ro Be	examiner? 1 Yes 2 No  Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 □ DOA Oth			nce 6 Other (Spe	ecity) HUSPICE
Division of	ing Ph	uo.	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Yi	(ear) 28b. Time o	Wor	yat k? Yes 2 □No	28d. Describe hor	w injury occurred	
S	Attend death ctor: y the i	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury	- At home, farm, str		res 2 🗆 140		reet and Number or R	ural Route Number,
2	s after s after al Dire ed in t	Certification; To	4 ☐ Homicide determined building, etc. (	Specify)			City or Town	, State)	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending i completely filled in by the funeral director, page 2 should be detached for use as	Medical (	29a. Certifier  (Check only 2 Medical Examiner: On the basis of example and manner stated	kamination and/or in	th occurred at the ti	me, date and place opinion, death occu	e, and due to the ca rred at the time, da	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)
	To the within to the comple	Mec	29b. Signature and title of certifier	u.	29c. Licens	e number	29	od. Date signed (Mon	th, Day, Year)
			/m^		DV	13725		9/251	4
•			30. Name and address of person who completed cause of deat	th (Item 23a) (Type,	Print) 2 vel (10	Rdin	hilmi	いかたつう	1107
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	-1-140			- 1017 2	- (()
	Registr		SFP 2 9 2009 Jensus	v B. A	acks				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 27, 2009 Rossman Gary Α. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** itizens Vursing Home De avre Birthplac Country) MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 27, 1946 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min 10 M 2 □ F 215-46-8699 63 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-f show must be notified at 1 Yes 2 No Director Harford MD Havre De Grace 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code U.S.A. 21078 155 Bloomsbury Ave items 23a Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Examiner and 2 should be filed within 72 hours after lealth and Mental Hygiene. m 27 is marked other than "natural", or ite 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) 12 Meat Cutter Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk unk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai Havre De Grace, MD 21078 155 Bloosbury Ave <u>Leeanna Rossman / Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 9/29/2009 Ardent Crematory Hanover, MD 22. Name and Address of Facility Maryland Cremation Services 21. Signature of Funeral Service Licensee 9-P.O. Box 1413 Baltimore, MD 21203 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bran Immediate Cause (Final alioblastom year Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine nding physician and use as the burial-trai Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death atten 3 Ectopic pregnancy Day signed by the atte Month Year in the past 12 months? 5 ☐ Other (specify) 1 Tyes 2 TNo 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, þ 2 No 3 Probably 4 ☐Unknown 1 Tes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 2 No To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28d. Describe how injury occurred 27. Manner of Death 1 ₩ Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Milham 120

32. Registrar's

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

errell Christophe	1	riyan Rodgers, Jr Sta - For State Registrar	ite of Maryland	-	rtment of tificate of		no ivientai	Hygiene	Reg.	No.	no	9 3116
Physicia	n/	<ol> <li>Oecedent's Name (First, Middle</li> </ol>	·					2. Date of Month	of Death	ey Yei	ar	3. Time of Death 0120 hrs
Medical Examin		Terrell Christop  4a. Facility Name (if not institution		-		o. City, Town, o	or Location of De		ember 2	4, 2009 4c. County	of Death	
		Northwest Hospital	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Randalisto				Baltimo	re Cou	nty
Funeral Director	2	19-83-0108	5. Sex 7. Ag	e (In yrs. Ia	st birthday) Yrs.	Months Da		vlin.	of Birth (1		Foreig	hplace (State or n untry) MD
any	-	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location	on						10d. Inside City Limits
daryland 28a-f show 1 at once.	٥	MD Baltim	pre	R	andallsto							1 Yes 2 No
ith the Maryland 23a or 28a-f sho	irect	10e. Street and Number	0: 1 [7]			10f. Zip Code			10g.	Citizen of W	hat Cour	ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral Director	3425 Carriage hill 11. Marital Status	12. Was Decedent	Ever in U.S			lispanic Origin?					can Indian, Black,
death or iten	nue	1 X Never Married 2 Ma	1 Yes 2	X No			an, Mexican, Pue	erto Rican, et	.c.)		te, etc.	
rs after ural", miner	اھ	Widowed 4 Divo	rced If Yes, Give Year or Dates:			Yes 2 X N	lo specify:	of work done	116	Specify: 6b. Kind of B		an-American
72 hour	Completed	Elementary/Secondary (0-12)	College (1-4 or				fe. DD NDT use				20.1100071	
yoge within iene. er tha	팂	n/a			n/a					n/a		
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours al nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural other traumatic event, the Medical Examin	Be C	<ol> <li>Father's Name (First, Middle, Terrell C.U.Rodger</li> </ol>					18.Mother's Na	ame (First, M Oglesby	iddie, Mai	den Surnam	e)	
2121: hould be fill ad Mental F is marked tric event, 1	္ျ	19a. Informant's Name/Relationsh	ip (Type, Print )				eet and Number	or Rural Rou				
e, MD 1 and 2 sh Health an item 27 i	- 1-	Tania Oglesby/ Moth 20a. Method of Disposition	er	20h E	3425 ( Place of Disposi		Hill Circ	le T1, l		1stown,		
Baltimore, MD pernit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	-	1 Burial 2 X Cremation	3 Removal from St	ate c	rematory or oth	er place)	- •	0-2-09			•	
Iltim nit. Pa artmen oortant	ŀ	4 Donation 5 Other Sp. 21/Si ature of Funeral Service I		/ ·	tro Crema 22. N					Baltimo Nome P.		Ralto. Co.
Balt permit. Departu Import injury		Dardon	M. aly	w	920	0 Libert	y Road, R	andalls	town,	MD 2113	13	
Physician /Medical		3a. Part I. Enter the disease, or a failure. List only one cause of	on each line.				g, such as cardia	ac or respirat	ory arrest	, shock, or he	eart	Approximate Interval Between Onset and Death
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		Sequentially list conditions,	b									
	ا <u>ۃ</u>	if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated	Due to (or as a cons									
Mg fed gM	Medical Examine	events resulting in death) Last	Due to (or as a cons	equence of	):							
D.O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transit	dica	UNPENDED	AMENDED			·						
3760 ificate t ig physi		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregr		al death	Ectopic pre	egnancy		23d. Date of		y Day Year
ox 68 ath cert ath cert attendir	Physician/I	past 12 months?  1 Yes 2 ✓ No 9 Unk	4 Pregnant a	t time of de		ner (Specify)						•
b. Bc the dea	Phy	Part II. Other significant conditi	9 UTIKHOWII	th but not re	esulting in the u	nderlying caus	e given in Part I.	236	e. Did toba	acco use con	tribute to	the cause of death?
P.C.	۵				, and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second	, ,		_ 1	Yes	2 V No 3	Prol	bably 4 Unknown
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On C ending sath. or: Af	tiol	1 Natural 5 Pend			FOUND: 0032 hrs	1	Yes 2 V No	Malpo	sition of	feeding t	ube	
ivisi or Att after de Direct	Certification:	3 Suicide 6 Could	28e. Place of li	njury - At ho	ome, farm, stree	t, factory, offic	e building, etc.	or	Town, Sta	te)		ural Route Number, City
Ospital hours uneral		29a, Certifier	mined (Specify) Mu		•	rad at the time	data and place	1				Randallstown, MD
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only   Certifying Pr	niner:Dn the basis of exa and manner stated	mination a	ge, death occur nd/or investigat	ion, in my opin	on, death occurr	ed at the tim	e, date an	d place, and	due to th	ne cause(s)
F	Be	29b. Signature and title of certifie					ense number					onth, Day, Year)
		D_M_(	In			0.0	C.M.E.			Septembe	er 24, 2	2009
3		<ol> <li>Name and address of person Donna M. Vincenti, MI</li> </ol>				Penn Stre	et, Baltimore	, MD 212	01			
St Regist	ate rar	31. Date files (40-ph, 29) 20	09 A32. Registra	ar's Signatu	re park							
regist	121											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician/ M. Reisser 9:45 PM Ivy 2009 September Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Co. <u> Holly Hill</u> Nursing & Rehab Towson If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Country Min 1 🖸 M 2 🔀 F Director Connecticut 36-28-0929 Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director Towson 1 ☐ Yes 2 X No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with United States 531 Stevenson Lane 21286 items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian Black, White, etc. 9 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White "natural" Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed within , Amental Hygiene (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other trainmant. McDonalds Restaurant 5 Years Hostess Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ivy M. McMillen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Unit 19a. Informant's Name/Relationship (Type, Print) Sparks, Maryland 14209 Quail Creek Way Alice M. Downes (Daughter) 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name o Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Holly Hill Mem. Gdns. Middle River, MD 9/23/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 21. Signature of al Service Lice lie 20 Dundalk. 7922 Wise Ave 23a. Part 1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each line ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, \pproximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ 94Ras disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exam certificate be executed and Due to (or as a consequence of): resulting in death) Last burial-t the attending physician the for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Atter this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 🗹 or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other 1 Yes 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury Natural 5 Pending JA Investigation Accident completed filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plactory of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital o within 24 hours af To the Funeral D Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day icense numbe 30. Name and address of person who completed cause of death (Item 23a) (Type

State Registrar 31. Date filed (Month, Day, Year)

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		For State Registrar	State of Ma	ryland / I		rtment of F		and M	-	giene Reg. No.	111	19	31164
Dhysisis		Decedent's Name (First, Middle, Last)				imodio or			2. Date of Dea			ear	3. Time of Death
Physicia /Medic		Ruby Jane Rose							Septemb	er 2	25, 2	009	7:17 P M
Examin	er	4a. Facility Name (If not institution, give :				4b. City, Town, o		of Death			County of		
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Page:		1X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State			emorial (		9/29,	/2009	Abe	rdeei	a, M	aryland
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		hock, or heart failure. List only on	cations that caused t e cause on each line	the death. Do	not ente	r the mode of dyir	ng, such as	cardiac c	r respiratory ar	rest,			Approximate Interval Between Onset and Death
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death	Completed by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnanc Other (specify) _	у				Mont	h	Day Year
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tendi leath. tor: A the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					Yes 2 □ I						
or At after of Direc	i i	4 ☐ Homicide determined	28e. Place of Injur building, etc.	(Specify)	arm, stre	et, factory, office		2	City or Tou	Street and n, State)	d Number }	or Rura	l Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Medical Certification: To	29a. Certifier 1 Certifying Phys	ician: To the best of	f my knowledge	e, death	occurred at the til	me, date ar	nd place,	and due to the	cause(s)	and man	ner as s	tated.
n 24 h	edic	(Check only 2 Medical Examir	er: On the basis of and manner stat	examination ar ed.	nd/or inv	estigation, in my o	pinion, dea	th occurr	ed at the time,	date and	place, an	d due to	the cause(s)
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		30. Name and address of person who con Westel Kloss	mpleted cause of de	4 .	(Type, P	rint)	72.	16-	en m	77	2120	6	
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2009 27, 9:45a M Sept. Robert Robusto /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Co. Bel Air Upper Chesapeake Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 3 - 12 - 1923 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Funeral Months Maryland 86 Director 217**-**14-0793 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Executive metals is notified at 1 ☐ Yes 2√2 No Funeral Director Harford Co. Bel Air MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 USA 12 Bonnie Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ NoWW I I 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 21 Married Specify: White 1 ☐ Yes 2 ☑ No Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Anchor Post &Elementary/Secondary (0-12) College (1-4or 5+) N/A Fencing Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jannie Nardone Michael Robusto 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothy Robusto-Wife Bonnie Avenue Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1  $\square$  Burial 2 $\dot{f X}$  Cremation 3  $\square$  Removal from State Bayview Crematory 9-28-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final YESARS **Physician** Schemic CARDIONYMAT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2000 1 □ Yes 2 } 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Depatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 5 Pending investigation **∠**Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Vital o To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Division

Baltimore, Maryland 21215-0036

Registrar

lason

DHMH 17 Rev 1/2001

attending physician a for use as the burial-1

signed by the a

500

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Birnbaum MI

D0056296

upper chesapeace Drive

09-07408 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Timothy Walter Sweeney State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1241 hrs **Medical Examiner** September 21, 2009 Timothy Walter Sweeney 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery Rethesda 6305 Macarthur Boulevard Apt. B1 If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign District of 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Min Director Country)Columbia 587-22-7022 1_XM 2 F Vrs March 17 58 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 V No Maryland Montgomery Rethesda within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20817 United States 6305 Macathur Boulevard Apt Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status White etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes 2 X No Yes 2 X No specify: Specify: White Yes, Give Yee Widowed 4 Divorced other than "natural", the Medical Examiner 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Roofer Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filed nent of Health and Mental Hyg is marked Be Edward A. Sweeney Patricia G∩van 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ٥ 2 t: If item 27 is other traumat 1120 Parkwood Avenue, Rockford Patrick Sweeney/ Brother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date September 25 Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State Important: | injury or oth 2009 Baltimore, Maryland Department Metro Crematory. Donation 5 Other Specify. Inc 22. Name and Address of Facility Cremation Society of Maryland. In 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road Baltimore Maryland 21228 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Medical Death Atheroscleortic cardiovascular disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed Physician/Medical AMENDED 23a,27, perME, g895 9/30/09 TT X UNPENDED attending physician for use as the burial Box 68760, 23d. Date of delivery IE EEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ö ģ Yes 2 No 3 Probably 4 ✔ Unknown σ. Completed Records, ficate has been s page 2 should b 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy The law performed? death? 2 No. ✓ Yes 2 No ✓ Yes certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical of Vital Be Hospital: 1 examiner? Other-Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 V Yes 28d. Describe how injury occurred After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of Injury 28c. Injury at Work? Certification 1 X Natural Division Yes 2 No Director: Pending 24 hours after death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined within 24 hours a

To the Funeral I (Specify) 4 Homicide

State

29a. Certifier

29b. Signature and title of certifier

**Medical** 

111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature Marken

**OCME** 

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

**DHMH 17 Rev 1/2001** OCME 2006

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 22, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year SEPTEMBER 19 2009 1502 EDWARD SMITH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMOKE

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nar. | 27, 1936 JOHNS HOPKINS BAYVIEW MEDICAL CENTER 9. Birthplace (State or Foreign 5. Social Security Number 220 – 30 – 3346 6. Sex 7. Age (In yrs. last birthday) ΜĎ 1 M 2 □ F 73 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD Baltimore Dundalk 1 ☑Yes 2 ☐ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 2127 Jasmine Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: Specify: White 3 ☐ Widowed 4 € Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Locksmith Self Emp. 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Edward Smith, Jr. Carlyn Morgan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2127 Jasmine Rd., Dundalk, MD 21222 Brenda Sellers 20b. Place of Disposition (Name of cemetery crematory or other pl Crestlawn Cem. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/25/09 Marriotsville, MD 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wesley Chavis, Jr. F.H 21. Signature of Funeral Service Linensee 2007-09 Eastern Ave. Baltimore, MD 21231 23a. Pa Enter the disease shock, or heart failure. complications that careed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, conly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 30 MINUTES EXTURATION OF PATIENT AS PER FAMILY REQUEST disease or condition resulting in death) Due to (or as a consequence of): 5 DAYS RESPIRATORY FAILURE Caquaintary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): CONGESTIVE HEART FAILURE, PNEUMONIA 5 DAYS PROGRESSIVE Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BRAIN DEATH 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 11 Yes 2 □ No 1√ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

/Medical Examiner sician and burial-trans Box 68760, the attending physician requires that the death certificate be the as use for P.O. detached þ Records, , page 2 should certificate Division of Vital director, After this funeral ( To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After the filled in by

Physician/Medical

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

Examine

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Be

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

with

hours after death

within 72

permit. Pages 1 and 2 should be filed withit
Department of Health and Mental Hygien
Important: If item 27 is marked other than
any injury or other traumetic.

**Physician** 

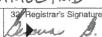
Maryland 21215-0036

Baltimore,

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GRACE THAMMASUVIMOL, MD 31. Date filed (Month, Day, Year)

SEP 29 2009



and manner stated.

Park

29c. License number RES-001

4940 EASTERN AVENUE BALTIMORE, MD

29d. Date signed (Month, Day, Year)

SEPTEMBER 19,2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_	For State Registrar			ertificate of		Re	g. No. 2009	81188		
Physicia	n	1. Decedent's Name (First, Middle, Las		Date of Death     Month	Day Year	3. Time of Death					
/Medica	1	Karen Ann  4a. Facility Name (If not institution, give	Saunders		4h City Town o	r Location of Death	Septembe	er 26,2009 4c. County of Death	7:20AM		
Examine	r	Dove House	e street and number)			tminster		Carro			
Funeral		5. Social Security Number 6. S		(In yrs. last birthda	) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		nplace (State or Foreign		
Director		218-64-5333	□ M 2 💢 F	56 Yrs.	Months Days	Hours Min.	June 30	1953 Wash	nington, DC		
and and	1	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits		
Mary field	5	MD Balti	more		Reisters	- orm			1 ☐ Yes 2 No		
r 28a	Director	10e. Street and Number	more		10f. Zip Code	LOWII	10	g. Citizen of What Cou	untry?		
h with		248 E. Chatswor	th Ave.			21136		USA			
ems (	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	B. Was Decedent of H		ecify Yes or No-	14. Race - Amer Black, White			
D3(	2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	1 ∐Yes 2 [X]N If Yes, Give Year or Dates:	0	1 □Yes 2 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	ite		
5-0	Completed	15. Decedent's Ed (Specify only highest gra	lucation (de completed)	16a. De	cedent's Usual Occup	ation during most of work	ing 1	6b. Kind of Business/I			
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Ind 21 be filed wil tal Hygien d other th event, the		12 17. Father's Name (First, Middle, Last)			Reception	18. Mother's Name	e (Eirst Middle M		s Office		
E ed la be	Re							,			
Marylar d 2 should be th and Menta 7 is marked traumatic ev	<u></u>	Edward Michael M  19a. Informant's Name/Relationship (		19h Ma	iling Address (Street			ginia Ander City or Town, State, Z			
		Scott_K. Saunders			3			ton, MD 21			
ore, M es 1 and 2 of Health of Health ritem 27 i		20a. Method of Disposition	3011		position (Name of ematory or other place			Oc. Location - City or T			
0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		l .	n Mem.Gar	i .	9/09	Finksburg,	MD		
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or other once.	- 1	21. Signature of Funeral Service Licer	isee		22. Name and Addre			Reistersto			
0 89 E E 8		1-21/45	£10/-	E	line Fune	ral Home	Reister	rstown, MD	21136		
		23a. Part 1. Enter to disease, or com shock, or heart failure. List only	plications that caused one cause on each line	the death. Do not e	-				Approximate Interval Between Onset and Death		
Physician	İ	Immediate Cause (Final disease or condition	. ENJ	) ST	AGE	C . O	, P. J	) -	Onset and Death		
/Medical Examiner	1	resulting in death)	Due to (or as a	consequence of):							
	_	Sequentially list conditions,	b	consequence of):							
uted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
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68760, tificate be executed g physician and as the burial-transit	edical		d								
		IF FEMALE:									
BOX eath cer attendin for use	sician/iv	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	☐ Fetal death	Ectopic pregnanc	y		23d. Date of deli Month	very Day Year		
requires that the death ceres signed by the attendir	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	Other (specify)						
that the detail detail	Ž.	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?		
Hecords, P.O. ne law requires that the de that been signed by the: ge 2 should be detached	o D						1 111	s 2 No 3 Pro	obably 4 🗌 Unknown		
() > = 0	ompieted						24a. Was an	24b. Were au	topsy findings available		
_ F # # E   .							autopsy perform 1 □ Yes 2	ed? death?	completion of cause of 2 □ No		
ysician: Tysician: ne	25. Was case referred to medical examiner?			201_200		h (Check only one					
this all districts	2 │	1 Yes 2 Ne		nt 2 ER/Outpat		4 LI Nursing Ho		nce 6 Other (Spec			
DIVISION OF VITA Il or Attending Physician: after death. Director: After this certific d in by the funeral director,		27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time Year) Injury	/ Wor	ryat k?  Yes 2 □ No	28d. Describe how	w injury occurred	House		
Vittenc death death ctor: y the	[ ]	3 ☐ Suicide 6 ☐ Could not be		rv - At home, farm,	street, factory, office	1165 2 110	28f. Location (Str.	eet and Number or Ru	ral Route Number		
	Certification:	4 Homicide determined	building, etc.	(Specify)	,		City or Town,	State)	, , , , , , , , , , , , , , , , , , , ,		
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To the within 2 To the comple	ME	29b. Signalure and title of dertifler	Mova	MA	29c. Licens	00542	18 8	od. Date signed (Month)	) - 09		
		30. Name and address of person who	3. Kane	ug 349	e, Print) Malcale	dure,	westn	ninsten M	D 2/157		
State	9	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1			-			
Registra	r	SEP 29	2009 Jane	un B.	parke			_			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept **Physician** 21 2009 11:50 PM arrie /Medical Baltimore 4c. County of Death 4a. Facility Name (If not institution, give Examiner NIA Hebrew Veriatric Ctr If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept 9 5. Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 84 Yrs. 216-36-6432 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar miss because. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 Nes 2 No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number reen 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Neyer Married 2 Married 1 Yes 2 Vol If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No ac Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Morker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be anks ၉ DUIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2124 19a. Informant's Name/Relationship (Type. Print) Mead Windson Mills MD 3307 Green 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Arbutus 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licenses 22. Name and Address of Facility Balto MD 21267 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) stage End dementiant sician 6 months Medical Due to (or as a consequence of **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Atteriding Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 3 Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cardlo my opathi 2 No 1 🔲 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🏋 No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 KInpatient Certification: To 1 Tyes 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12009 D0053928 22

State Registrar 2434

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

parks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. BELVEDERE AVENUE,

29

32. Raistrar's Signature

SURAITA

BALTIMORE

BEGUM, MD

21215

, MD

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				ertificate of Death		ene 3. No. 2009						
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Mary E. Simms			24, 2009 ^{ear}	3. Time of Death 7:45 Р. м					
	Examin		4a. Facility Name (If not institution, give street and number)  Morning Side House	4b. City, Town, or Location of Deat Satyr Hill		4c. County of Death Baltimore						
ŀ	Funeral Director		5. Social Security Number  6. Sex 1 M 2 K 7. Age (In yrs. last birthda, 83 Yrs.  Usual Residence of Decedent	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	3. Date of Birth (Month, Day, Y January 17	^(ear) 1926 Mar	hplace (State or Foreign untry) yland					
	Maryland a-f show	tor	10a. State 10b. County 10c. City, Town or	ocation ville			10d. Inside City Limits 1 ☐ Yes 2 ☐ No					
	th with the 23a or 28a	al Director	10e. Street and Number 8800 Hanford Road	10f. Zip Code <b>21234</b>	10g	. Citizen of What Cor USA	untry?					
9800	s within 72 hours after death with the Maryland glene. Ir than "natural", or items 23a or 28a-f show It et l'sical Extrainer met to traiff of the	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify:						
Maryland 21215-0036	within 72 ene. <b>than "na</b>	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	redent's Usual Occupation re kind of work done during most of wor DO NOT use retired)  DETVISON	rking	C & P Telept						
land 2	vuld be filed v Mental Hygi arked other atic event, tr	To Be C	17. Father's Name (First, Middle, Last) Ernest R. Finch		ne (First, Middle, Ma.	<u>.</u>						
	ges 1 and 2 should be filed nt of Health and Mental Hyg : If item 27 is marked othe or other traumatic event,		Wade T. Simms/Grandson	ling Address (Street and Number or Ri 27 Gates Avenue East B			Zip Code)					
Baltimore,	permit. Pages 1 Department of H Important: If iter any Injury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition cemetery, of Parkwood	position (Name of ematory or other place)  Cemetery 9/		Baltimore Ma	,					
Bal	permit Depar Impor any In		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Bal	timore Maryl	and 21214						
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	Thrive		ι,	Approximate Interval Between Onset and Death					
68760,*	rificate be executed  By physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	e Alzheir	ners		unknown					
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as a completely filled.	Physician/Mec		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deli Month	ivery Day Year					
	quires that en signed b uld be deta	Š	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to	the cause of death?					
Division of Vital Records,	: The law re cate has ber page 2 sho	Completed			24a. Was an autopsy performe 1 □Yes 2 □	prior to death?	topsy findings available completion of cause of					
<u> </u>	sician certifi rector	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: 1 ☐ Inpatient 2 ☐ EB/Outpatient	Other:	ath (Check only one)	5.3	A i =					
ion of	nding Phy tth. : After this e funeral d	Certification: To	27. Manner of Death 1 Natural 5 Pending Investigation 1 Inpatient 2 ER/Outpati 28a. Date of Injury (Month, Day, Year) 1 Accident Investigation	of 28c. Injury at	lome 5 Residence 28d. Describe how		oify TL					
Divis	tal or Atte	Certifica	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,					
2	To the Hospital or within 24 hours after to the Funeral Director completely filled in I	Medical										
	To the within To the COM	2	29b. Signature and little of certifier  Millian Est CRAF	29c, License number <b>R/D799</b>	5 29d	Date signed (Month) 9   25	n, Day, Year)					
			30. Name and address of person who completed cause of death (Item 23a) (Type 705 District OR 5 to	G. Linthic	iun, 1	UD Z	000					
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year William Eugene lal 2009 3:20 PM a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 5010 Garrison Street St. Leonard Calvert 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min 1 M M 2 □ F Director 213-26-9307 78 4/9/1931 Maryland Usual Residence of Decedent 10a. State 10b. County 28a-f show 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f st event, the Modical Examination mind be notified Director 1 ☐ Yes 2 ☑ No MD Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5010 Garrison Street Funeral 20685 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 2 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Baltimore, Maryland 21215-16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 MD State Police Officer Law Enforcement is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Oswald Berlington Tall Daisy Etheldra Phillips ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie Tall/ Wife 5010 Garrison Street, St. Leonard, MD 20685 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/29/2009 | Hanover, Maryland 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 21. Signature Funeral Se e Licens 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P., Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** OP disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Commeny Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): the attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery ☐ Live birth 2☐ Fetal death☐ Pregnant at time of death☐ 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Duknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ardiomopath Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \( \sum \) Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 24 hours after deatle Funeral Director: the 0

Registrar

Medical

29b. Signature and title of certifier

29a, Certifier

(Check only

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOOYOU

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

waldert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician Day Month Year September 25 lownes 0531 HM /Medical 2009 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Sinai Baltimort Bulhmore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. A. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Dec. 25 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 5 Year) Hours 219-28-0593 Director Usual Residence of Decedent 10a, State 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? ō items 23a Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married p If Yes, Give Year or Dates: 1 ☐Yes 2 ☐ NO Specify: Completed by Blac 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and 2 should be filed within lealth and Mental Hygiene. m 27 Is marked other than College (1-4or 5+) beneral abore 17. Father's Name (First, Middle, Last) or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) ဥ mue 19aj Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2126 permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is 3832 Granada Gwynn Oak, MD lownes nuspaval 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Injury ( 4 ☐ Donation 5 ☐ Other (Specify) emetail 21. Signature of Juneral Service Licens 22. Name and Address of Facility towerd Heights Au, Balto MD 2120 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardio **Physician** /Medical Due to (or as a consequence of): Examiner therosclero he Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ couleye 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 100 2 🗆 No 1 ☐ Yes 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier

the Hospital or Attending Physician. The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, been signed by the should be detached e Funeral To the within 2

21215-0036

Maryland

Baltimore,

State Registrar

2

DHMH 17 Rev 1/2001

FLOEN G.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

50693

Balthrort

29d. Date signed (Month, Day, Year)

Sustember 25, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** OBERT VALERIE 00:35 AM SEPTEMBER 23 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE N/A JOHNS HOPKINS BAYVIEW MEDICAL CENTE 8. Date of Birth (Month, Day, Year)
Time 7,1936 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 13€ M 2 ☐ F Months Days Hours 73 Director 212-34-6707 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Director Dunda1k Maryland Baltimore 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States Funeral 3125 Walford Drive Apt. F 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give' Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X□No þ Specify: Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 Years Sales permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If item 27 is marked other a may injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lena Valino Albert Valerie ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21221 2224 Middleborough Road Essex, Maryland Mr. Robert J. Valerie (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 9/28/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Physician SYSTEM ORGAN NULTI 3 HOURS /Medical Due to (or as a consequence of) Examiner EPSI 10 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed Sician and burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending death. 2 Accident Investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide

State

completely

29a. Certifier

(Check only one)

ERIC S

29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

4940 CASTERN

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

AUENUE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

SEPTEMBER 23, 2009

Division of Vital Records, P.O. Box 68760. or Attending 24 hours Fo the I within ?

State

Medical

31. Date filed (Month, Day, Year) SEP 2.9 2009

MANJUNATH

29b. Signature and title of certifier

3 Suicide

29a. Certifier (check only

one)

4 Homicide

6 ☐ Could not be

MARKAND 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MD

ume

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

000

Registrar

DHMH 17 Rev 1/2001

28f. Location (Street an, Number or Rural Rou Number City on November 1 Syenuel Ballimorê

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

UPU /TA

SEPTEMBER 19, 2009

4111001397

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** /Medical 4a. Facility Name (If not institution give street and no 4c. County of Death Examiner 9. Birthplace Country) W York **Funeral** Months Min. 1 □ M 2 X F Days Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the profiled at Funeral Director 1 ☐ Yes 2 No MD Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20657 674 Gunsmoke Circle 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∏Yes 2 No <u>ک</u> If Yes, Give White 3 X Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crossing Guard Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Wagner Lena Ehleers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Wells III/ Son 674 Gunsmoke Circle, Lusby, MD 20657 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 9/29/2009 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** noce /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year ☐ Pregnant at time of death 5 Other (specify) Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Aesidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 ✓ Certifying 2 ☐ Medical E niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of contifie 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Dav Year **Physician** COMMIE 27th WILLIAMS 7:20 AM 2009 SEPTEMBER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE Randallstown GENESIS RANDALLSTOWN CENTER Birthplace (State or Foreign Country)
 N C 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1**⊠**M 2□ F Months Days 75 209-26-9674 Director Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at XXYes 2 □ No Director MD NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21207 3204 Burnbrook Lane Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23s 12. Was Decedent Ever in U.S. Armed Forces? 1 △ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc.African Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: American þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Barber Self-employed 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Williams Bower**s** Sylvester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3204 Burnbrook Lane Baltimore, MD. 21207 Tonya Anderson-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mem. Pk. Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once, 14 Burial 2 □ Cremation 3 □ Removal from State 09-29-09 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemia Myocardial **Physician** disease or condition resulting in death) /Medical Due (or as a consequence of): Disease-multivessel **Examiner** Coronan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine P.O. Box 687607 The law requires that the death certificate be execute physician and the burial-tran Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by secondary 1 Tes 2 No 3 Probably 4 Wallunknown 10/1 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has trector, page 2 s autopsy perform 1 ☐ Yes 2 🕱 No 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined Micrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058965 SEPTEMBER 28th 2009

State Registrar

71

31. Date filed (Month, Day, Year)

SAIMA

Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of deat (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 26,2009 21:32 PM September /Medical James A. Warren. Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Square Baltimore Rosedale tranklin Hospital Center 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Oct. 21 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 17€XM 2 ☐ F 213-50-6766 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 28a-f show injury or other traumatic event, the Medical Examiner must be nutified at 1 ☐ Yes 2 No Director Towson Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United States "natural", or items 23a 21204 Funeral 934 Dunellen Road Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Warren, James Baltimore, Maryland 21215-0036 1 ☐ Yes 2√No Specify. Specify. ģ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Realtor 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Esther M. Yox James A. Warren, Sr. ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 Irving Place Pikesville, MD 21208 19a. Informant's Name/Relationship (Type. Print) Annette Tracey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🔀 remation 3 ☐ Removal from State 2009 Sykesville, MD South Carroll Crematory Sept. 28, 4 ☐ Bonation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, PA 21. Signature of Funeral Service Licensee Sykesville MD 21784 1212 W. Old Liberty Road 23a. Part 1. Enter the disease, or complic hock or heart failure. List only on Approximate Interval Between Onset and Death nons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. ediate Cause (Final **Physician** povolemic dis ase or condition res (ting death) /Medical Examiner Intrachdomino Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner End Stage
Due to (or as a consequence of): sician and burial-trans resulting in death) Last P.O. Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23h. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown signed by t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation within 24 hours after common to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature-and title of certifier S. Nadighr M.D 26/09 KES00000

Registrar
DHMH 17 Rev 1/2001

State

Franklin Square Unive, Dept of Internal Medicine, MD, Foredale 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

9100,

31. Date filed (Month Day, Year)

09-07507

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Jamal White 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day Y September 26, 2009 0115 hrs Medical Examiner Jamar Antwan Nathaniel White 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Raltimore University Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral UNK Months Davs Country) MD Director 23,1983 26 uq.  $_{1}X_{M}$ 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 No Baltimore Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygene I important: If iten 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be political at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 4716 Pimlico Road USA 14 Race - American Indian Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes Specify: Black Yes 2 X No specify: If Yes, Give Year 3 Widowed Divorced á 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Construction 12 Laborer Com 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) onald D. White, Sr. Janice Mack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Janice White (Mother) 2136 N. Fulton Ave. Baltimore, MD 21217 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition crematory or other place 1 XBurial 2 Cremation 3 Removal from State 10/06/09 Mt. Dundalk, MD Carmel Cem. Donation 5 Other Specify: 22. Name and Address of Facility Wesley Chavis, Jr. 21. Signature of Funeral Service Licens 2007 Eastern Ave. Baltimore, MD 21231 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician Between Onset and failure. List only one Death Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter U. Jerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): The law requires that the death certificate be execu Physician/Medical UNPENDED AMENDED ed by the attending physician detached for use as the burial -Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 3b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o è 1 Yes 2 V No 3 Probably 4 Unknown Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? has 2 s performed? 2 No ✓ Yes 2 No. 1 V Yes page After this certificate 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Division of Vital Be examiner? Other₄ Hospital: 1 V Inpatient Nursing Home 5 Residence 6 Other: ER/Outpatient 3 DOA 2 Certification: To 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year Sep 26, 2009 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Subject shot 0017 hrs Yes 2 V No 1 Natural 5 Pending hours after death. To the Funeral Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 1800 Dover Street, Baltimore, Md. Suicide (Specify) Local Street 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 26, 2009 O.C.M.E. o completed cause of death (Item 23a) 30. Name and address of person w 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner Jack Titus MD. 31. Date filed (Month, Day Year) SEP 2 9 2009 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician		Decedent's Name (F	irst, Middle, i	Last)							2. Date of		\au_	V	3. Time of Death
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ineral		Social Security Numb		.Sex 1 ☐ M 2 🔯 F		rs. last birthday Yrs.	) If Under Months	Days	Hours	Min.	8. Date of (Month,	Day, Yea	66	9. Birthp Coun	lace (State or Foreig htry) MD
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		due to pro		aneurys	on.							s 2 5	No	1 🗌 Yes	2□ No
á		<ol> <li>Was case referred examiner?</li> <li>Yes 25/Ne</li> </ol>	to medicat	Hospital:	Inpatient 2	2 🗌 ER/Outpatio	ant 3 🗆 D	Ott		,	ath <i>(Check or</i> Iome 5□ F		6 🗆 🔾	her (Snecii	6/1
		7. Manner of Death			e of Injury onth, Day Yea			28c. Inju		(diam'g)	28d. Descr				777
14	200	2 Accident	Pending investiga	tion	min, Day 19a	r) Injury	м		Yes 2	□No					
41414		3 ☐ Suicide 6	Could no determin	od   200. Flat	ce of Injury - A	At home, farm, s	treet, factor	y, office				on (Street Town, St		ber or Run	al Route Number,
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1	medical Certification:	one) 9b. Signature and title	of certifier	and ma	nner stated.		290	c. Licens	se numbe	r		29d.	Date sign	ed (Month	Day, Year)
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Hospital or Attending Physiclan: The law requires that the death certificate be executed Box 68760, P.O. I Division of Vital Records, certificate After death.

Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 ™ Widowed 4 □ Divorced White Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Firm 12 yrs. Bookeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wolfe Enoch Parrish Beulah 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 536 Old Mill RD. Millersville, MD 21108 Mrs. Patricia L. Courtney/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 09/30/2009 Crownsville, Maryland 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Lieensee Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications at at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final days disease or condition resulting in death) Ommunit Due to (or as a consequence of) Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of) by Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the und<u>erly</u>ing cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗌 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Deatl 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes nours after death. neral Director: A filled in by the fu 2 No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation is examined. 29a. Certifier Medical (Check only 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) halm NOV 10 32. R egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

7. Age (In yrs. last birthday)

10c. City, Town or Location

Millersville

71

ROME

Facility Name (If not institution, give street and number,

10h County

536 Old Mill Road

more

217-34-3324

Washinat

6. Sex

Anne Arundel Co.

1□M 2×F

Certificate of Death

Months

Towin, or Logation of Death

Hours

21108

en

Days

If Under 1 Year | If Under 24 Hrs.

Durnie

Min.

2. Date of Death

extember

8. Date of Birth (Month, Day, Dec. 13,

Dec.

() Month

3. Time of Death

10d. Inside City Limits

1 ☐ Yes 2 No

PM

1:43

Hrunde

9. Birthplace (State or Foreign Country)
Baltimore, MD

Year

200

4c.,County of Death

MNP.

10g. Citizen of What Country?

United States

1937

Wilbert Young		S 1- For State	tate of Maryl	and / Departn	nent of He			2 n	00 3118
Physicia		Registrar  1. Decedent's Name (First, Mid	dle,Last)		Cale of Dec		2. Date of Dea	eg. No. 😘 🔾 th	3. Time of Death
Medical Exami		WILBERT	PU	RNELL	Y	DUNG	Month Septembe	Day Year er 25, 2009	1700 hrs
		4a. Facility Name (if not institute 1100 Bolton Place			4b. City	y, Town, or Location		4c. County of I	Death
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last b	oirthday) If U	nder 1 Year If Und	er 24Hrs. 8. Date of Bir		9. Birthplace (State or
Director		214-50-7231	1 M 2 F	1-0	Yrs. Mor	nths Days Hour	s Min.	11949	Country) Mary Jand
		Usual Residence of Decedent							11141 974174
W any		10a. State 10b. County	,	10c. City, Tow	n or Location				10d. Inside City Limits
Aaryland 28a-f show 1 at once,	ē	MARYLAND M	SA		BALT	Zip Code	RE		1 Yes 2 No
	Director	10e. Street and Number	. 9_	0- 1		Zip Code	1	0g. Citizen of What	Country?
ith the 23a or notifie		1100 300 11. Marital Status		, APT. 11		2126		U.S.F	7.
ath w	neral	1 Never Married 2	Married Armed F				gin? ( Specify Yes or No n, Puerto Rican, etc.)	14. Race - / White, e	American Indian, Black, etc.
ter de	/ Fun	3 Widowed 4 D	1 Yes ivorced If Yes, Give Ye or Dates:	2 ☑ No ar	1 Yes	2 No specify	:	Specify:	BLACK
5-0036 led within 72 hours afterlygiene. other than "natural", the Medical Examiner	d by	15. Decedent's Education (Sp	or Dates: ecify only highest gra	ide completed) 16a	a. Decedent's Usu	al Occupation (Give	kind of work done	16b. Kind of Busin	
6 172 h cal En	를	Elementary/Secondary (0-12	) College (	1-4 or 5+)	during most of v	vorking life. DO NOT	use retired)		
5-0036 led within 7 Hygiene. other than	Completed	12TH GRADE			0.	RDERLY			PITAL
15-C		17. Father's Name (First, Middle		1/0			r's Name (First, Middle, I	· .	7.150
D 21215-( should be filed v and Mental Hygi 7 is marked oth	To Be	19a. Informant's Name/Relation		<u> 70</u>	9b Mailing Addre		MDE TO Rural Route Num		State Zin Code)
MD 3	$\vdash$	VANDESSA YOU							ORE, MD21215
e, N I and Health item		20a. Method of Disposition		20b. Place	of Disposition (A	lama of samulas.	D-4-	100-1	1 T Olivia
MOre, Pages 1 and bent of Healt in if item		1 Burial 2 Crematic		rom State crem	atory or other place	ce)	9-29-09	Bartin	noce, Maryland
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traus	ŀ	4 Donation 5 Other 5 21. Signature of Funeral Service		100	22. Name a	nd Address of Facilit	y	JAC / 111	AL HOME
in In Per Dep	- 1	Die Tric	MN.U	Muain	2140	N. FUCT	OWN IVE S	ALTIMO	CE, MD 21217
Physician		23a. Part I. Enter the disease, of failure. List only one caus		caused the death. Do	not enter the mod				Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final diseas		rotic Cardiovasc	ular Disease				Death
	- 1	or condition resulting in death)	Due to (or as	a consequence of):					
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):					-
Λ.	Examiner	name. Enter Underlying Cause (Disease or injury that initiated	C				15.00		
199, B is		events resulting in death) Last	Due to (or as	a consequence of):					
execu an and al - trz	dical	UNPENDED	AMENDED						
60, ate be ex hysician te burial		IF FEMALE:	23c. If yes,	outcome of pregnanc	·v			23d. Date of de	livery
687 ertific ding p	a	23b. Was decedent pregnant in past 12 months?	the 1 Live	birth	2 Fetal dea	th 3 Ectopi	c pregnancy	Month	Day Year
Box 6876 e death certificate the attending phy ed for use as the b	Physician/M	1 Yes 2 No 9 U	7 7	nant at time of death	5 Other (S	pecify)			
ords, P.O. Box 6876 w requires that the death certificate s been signed by the attending phy should be detached for use as the t		Part II. Other significant cond		A CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR	ing in the underlyi	ng cause given in P	art I. 23e. Did to	bacco use contribu	te to the cause of death?
P.C es that igned be deta	ğ	Diabetes Mellitus					1 Yes	2 No 3	Probably 4 VI Unknown
cords, law requir has been s	Completed						24a. Was		re autopsy findings available
Reco The law icate has	臣							rmed? dea	
Division of Vital Records, P.O tal or Attending Physician: The law requires that it as after death.  **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact		25. Was case referred to medic	al			26 Place of Death		2 No 1	Yes 2 No
Vital hysician: this certiful director,	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 ER/	Outpatient 3	DOA Other	Nursing Home 5	Residence 6	Other: Scene
ing Pt After		27. Manner of Death	28a. Date (Mont	of Injury h, Day,Year)	. Time of Injury	28c. Injury at Worl	28d. Describe I	now injury occurred	
ion ttendi death.	턣		ding estigation			1 Yes 2	No		
Ivis In A after of Direc	Certification:		lid not be	ce of Injury - At home,	farm, street, facto	ory, office building, e	tc. 28f. Location (s or Town, S		or Rural Route Number, City
Dospital hours uneral		4 Homicide	ermined (Specify,						
Division of Vital Records, P.O. Box 6876( To the Hospital no Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	ica Ea	(Check only	aminer:On the basis	of examination and/or			ace, and due to the caus ccurred at the time, date		
To t To t	Medical	29b. Şignature and title of certif	and manner:	stated.		9c. License number	, _ 310		(Month, Day, Year)
		D. T. U	1200	0		O.C.M.E.		September 2	
2	ŀ	30. Name and address of perso	n who completed cau	se of death (Item 23a)	)				
3		Patricia Aronica-Polla	k MD. Assist	ant Medical Exa	miner 111	Penn Street, Ba	altimore, MD 2120	1	
	ate	31. Date file (SEP), 23 2	109 232.R	egistrar's Signature	barks				
Regist	-	377 63 61	103 ~	100					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** DUN G EE 10:40 AM 2009 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** K2 Homer Uture ar Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 XE 6 MI **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director TIMOR 10g. Citizen of What Couptry 10e. Street and Number 10f. Zip Code eights Funeral within 72 hours after death . Was Decedent Ever in U.S. Armed Forces? 1 __Yes 2__No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life., DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) tomemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finand Mental F Be OUNG Williams JORMAN ouise. 19b. Mailing Address (Street and Number or Rural Route Number, Cityor Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) jes 1 and 2 sh t of Health and If item 27 is n 9264 Throgmorton Olita 1)aughter so lomon 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If it any injury or o □ Surial 2 □ Cremation 3 □ Removal from State MARyland Menorial 2/09 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4600 LBERTY Hehrs BY WOUNTER Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed burial-tran Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical as the IF FEMALE: for use yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy in the past 12 mont 1 Yes 2 No 9 Unknown Day Month Year Pregnant at time of death 5 Other (specify) signed by the a d be detached for 23e. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 ☐ Unknown 1 🗌 Yes certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐Yes 2 No Hospital or Attending Physician: 724 hours after death.
Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Siar 29c. License number s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 21215

State Registrar

31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

**ORIGINAL** 

2600

			1 - For State Registrar	State of Ma	aryland			nt of Hotel		and M		Reg. No.	2009	31183
	Physici	an	1. Decedent's Name (First, Middle, Las								2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Alberta Grace Alco				4h City	Town or	Location o	f Death	Sept.	16	2009 County of Death	2:35 A M
	Examin	er	Coffman Nursing H					gerst		Doduit			Washing	
	Funeral	V.	5. Social Security Number 6. S	ex 7. Ag	e (In yrs. las	t birthday)	If Unde	r 1 Year	If Under 2	24 Hrs. Min.	8. Date of Bird			place (State or Foreign intry)
	Director		188-20-3907	□M 2 <b>⊠</b> F	84	Yrs.	Months	Days	Hours	WIII I.	8. Date of Bin (Month, Da 09/05/	1925		PA
-	pue A		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							10d. fnside City Limits
	Maryl f sho	lor	MD Washing	ton	На	agers	town							1X Yes 2 ☐ No
	r 28a	irec	10e. Street and Number		1			p Code					en of What Cou	intry?
	be filed within 72 hours after death with the Maryland the Vigine. d other than "natural", or items 23a or 28a-f show avent, It o Medical Executar must be notified at	Funeral Director	1304 Pennsylvania	Avenue			2	21740				U	JS 	
	r dea	uner	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Dece 1 Yes, spe	edent of His	spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	- 1	<ol> <li>Race - Amer Black, White</li> </ol>	
30	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔼 1 If Yes, Give Year or Dates:	No.		1 🗆 Yes	2₩ No	Specify:				Specify: W	hite
9500-61212	2 hou		15. Decedent's Ed	lucation		16a. Deced	dent's Usu	ual Occupa	ition			16b. Kin	d of Business/l	ndustry
C   Z	hin 73	pie	(Specify only highest gra	de completed) College (1-4or 5	5+)	(Give life. L	kind of wi DO NOT i	ork done d use retired)	urin <b>g</b> most )	t of worki	ng			
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Maryiand	buid be fil Mental H arked oth atic even	Be	17. Father's Name (First, Middle, Last) George Robert Glo								e (First, Middle) cace Mc.			
Š	should ind Men ind Men ind Men ind Men ind Men ind Men ind Men	ြ	19a, Informant's Name/Relationship (	_	- 1	19b. Mailin	na Addres	s (Street a					Town, State, Z	ip Code)
_	7 18		James C. Failor	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,									n, MD 21	
ē,	os 1 and of Health item 27 other tr		20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Na	me of other place	9)		Date	20c. Loc	cation - City or 1	own, State
Ĕ	Pages ment of I ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)			Have				09/2	1/2009	Hag	erstown	, MD
Baltimore,	permit. Pages 1 Department of H Important: If Ite eny injury or ott		21. Signature of Euneral Service Licer	500	,									neral Home
	205 e a		23a Borth Enter the diseases or com	olinations that causes	) the death								cown, M	Approximate
20			23a. Part1. Enter the disease, or com shock, or heart failure. List only fmmediate Cause (Final	one cause on each li	ne.	DO TIQUE	or the 1110	de or dying	g, such as	cardiac	or respiratory a	11031,		Interval Between Onset and Death
· .	Physician /Medical		disease or condition resulting in death)	a. Venu Due to (or as	a conseque	once of):								15%
	Examiner		0	- Camar	ective	· U	ear	A +	ad	len	R			104
	• # ±	iner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	nce of):		1						/
	ecute and I-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	ince of):								
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	uficate g phys as the			g										
X D	leath certificat attencing phy I for use as the	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic p	oregnancy				2	3d. Date of deli	very Day Year
о. П	The faw requires that the death certifica te has been signed by the attending phage 2 should be detached for use as the	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of dea	ith 5	Other (s	pecify)					MORITI	Day
J.	<ul> <li>requires that the debeen signed by the should be detached</li> </ul>	, Ph	Part II. Other significant conditions of	ontributing to death b	out not resulti	ing in the u	nderlying	cause give	en in Part f		23e. Did 1	tobacco u	se contribute to	the cause of death?
Hecords,	uires sign ld be							_			1 🗆	Yes 2	□No 3□Pro	obably 4 hknown
Ö	s beer	ojete									24a. Was		24b. Were au	topsy findings available
ž	rsician: The law s certificate has b director, page 2 s	Completed										psy ormed? 2 No	death?	completion of cause of 2 No
		Bec	25. Was case referred to medical examiner?						26. Place	of Deat	h (Check only			
>	Physic this ce ral dire	၉	1 ☐ Yes 2 So		ent 2 Ef				4)=-NU	rsing Ho			Other (Spec	cify)
u C	ding F	ion:	27. Manner of Death  1 ***D**Autural 5   Pending 2 **T Accident investigation	28a. Date of Inju (Month, Da	y Year)	8b. Time of Infury	t M	28c. Injury Work	vat ⟨? Yes 2□	No	28d. Describe	now injur	y occurred	
Division of	death death ctor: y the	ficat	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inj	ury - At hom	ne, farm, str			.05 2	-				ral Route Number,
2	el or / s after of Dire	Certification:	4  Homicide determined	building, et	tc. (Specify)						City or To	wn, State,	)	
	To the Hospitel or Attending Physician: within 24 hours after death or to Funerel Director. After this certific completely filled in by the funeral director,	Medical (	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example	ysician: To the best niner: On the basis o and manner st	f examinatio	ledge, deatl on and/or in	h occurre vestigatio	d at the time n, in my op	ne, date an pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	within 2 within 2 To the I	Me	29b. Signature and title of certifier				29	9c. License	number			29d. Dat	e signed (Monti	h, Day, Year)
)				E (2)				D	SZ	32	7	09	-16-	2009
,	11 12		30. Name and address of person who								100			
<b>2</b> 21	H-12		Muhammad Khalid		D 1126 rar's Signatu		L Cou	ırt,	Hager	stow	m, MD			
	Sta Registi		31. Date filed (Monti SEP Year)	2009	604	1. 1	Conta							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 10, 2009 7:21 A M Mattie Altheria Atherholt Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Crofton Convalescent & Rehab Center Crofton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. July 8, 1922 Director Pennsylvania 199-12-6677 87 Usual Residence of Decedent 2 should be filed wittin to.
It and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f snover it marked other than "natural" or items 25a or 28a-f snover it marked other mast be notified at or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11508 Chantilly Lane 20721 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. δ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🗓 No Specify Specify: White Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mattie Pringle Litz Edward Banta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 11508 Chantilly Lane Mitchellville, MD 20721 Bonnie L. Turner/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fern Knoll Cemetery 9/14/2009 Luzerne, Pennsylvania 21. Signature of Juneral Service L 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ auac disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transi death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 20 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 Yes Other ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide illed in by the fu Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

Box 68760

P.O.

Records,

**Division of Vital** 

(Check

Aditya

29b. Signature and title of certifi

person who completed cause of death (Item 23a) (Type, Print)

tical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D57028

#231 Annapolis MD 21401

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

e Lashawn	1-	For State	tato or marytario	Certifica	ent of Health ar ate of Death		Reg. N		09 31
Physicia	n/ 1	eqistrar . Decedent's Name (First, Midd					2. Date of Death Month Da September 1	y Year	3. Time of Death 1352 hrs
cal Examir		Patrice L.  a. Facility Name (if not instituti		r)	4b. City. Town, o	or Location of Dea		4c. County of Deat	h
J.	4	a. Facility Name (If not instituting Laurel Regional Hos)		1)	Laurel			Prince Georg	
Funeral Director		5. Social Security Number 578-04-5747		ige (In yrs. last bir	thday) If Under 1 Ye  Months Da			MM/DD/YYYY) 9. Bi Forei 0 4 , 1 9 7 7 ^C	an
v any		Jsual Residence of Decedent  10a. State 10b. County		10c. City, Town					10d. Inside City Limi
land f shov	호		ce George	Laurer	10f. Zip Code		10g.	Citizen of What Co	untry?
he Mary or 28a		10e. Street and Number 14805 Ashfo:	rd Court		20707		US		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland enen of Health and Mental Hygiene.  If if item 27 is marked other than "natural", or items 23a or 28a-f show intent traumatic event, the Medical Examiner must be notified at once.	L	11. Marital Status 1 X Never Married 2	Married 12. Was Decede Armed Force		13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	White, etc.	erican Indian, Black,
her de ", or		3 Widowed 4	Divorced If Yes, Give Year or Dates:		1 Yes 2 X			Specify: B1	
ours at atural kamin	d b	15. Decedent's Education (Sp	pecify only highest grade c		Decedent's Usual Occu during most of working I	oation (Give kind ife. DO NOT use	retired)	6b. Kind of Business	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after pegarment of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", injury or other traumatic event, the <u>Medical Examiner</u> .	Completed	Elementary/Secondary (0-1)	College (1-4 o	r 5+) Re	ceptionis		C	urisman	Honda
21215-0036 Juld be filed within 7 Mental Hygiene: marked other than ic event, the Medica	E .	17. Father's Name (First, Midd	_				me (First, Middle, Mai	iden Surname)	
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212 ould b d Men s marl	5	19a. Informant's Name/Relation		11	9b. Mailing Address (St 14805 Ashi	reet and Number	or Rural Route Numbe	er, City or Town, Sta el Marv	ate, Zip Code) Land 2070
MD nd 2 sho alth and m 27 is		Pamela Cary	(Mother)		of Disposition (Name of		Date 2	20c. Location - City	or Town, State
or Hea		20a. Method of Disposition 1 X Burial 2 Cremat	ion 3 Removal from	State crema	atory or other place)	Į.	24 00	11 inton	Maruland
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite Injury or other tr		4 Donation 5 Other	Specify:	Resu	rrection (		1-24-09 L	Tinton	Maryland DC 20011
Baltin permit Departm Importa Injury o		21. Significant of Funeral Services	ce License	. 10	Tryrone .	T Youn	a 719 Ke	nnedy Si	t. NW Was
Physician /Medical kaminer		23a. Part   Enter the disease, failure. List only one cau	ase a. <b>Hyperte</b> i	nsive ca	not enter the mode of dy	ng, such as cardi	ac or respiratory arres	t, shock, or heart	Approximate Inte Between Onset Death
anime		or condition resulting in death		onsequence of):					
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):					
ed nsit	Examine	cause. Enter Underlying Cau Disease or injury that initiate events resulting in death) La	d	onsequence of).					
executed ian and ial - transit	<u>~</u>	X UNPENDED	X AMENDED	#2 as no	ted, 23a,PI	T.27.per	ME, G899 1	/8/10 TT	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Function: After this certificate has been signed by the attending physician and completely filled in by the function intender, filled in by the function that the completely filled in by the function that the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant past 12 months?	in the 23c. If yes, ou	tcome of pregnan	cy 2 Fetal death	3 Ectopic pr		23d. Date of deli Month	very Day Year
Box death he atte	ysi	1 Yes 2 No 9	0			show to Bort f	23e Did tot	nacco use contribut	e to the cause of death
S, P.O. Boures that the density of the designed by the id be detached if	2	Part II. Other significant con	nditions contributing to ca, seizure d				1 Yes	2 No 3	Probably 4 V Unknown
cords, law requir has been s	Completed						autops perform	med? deal	r to completion of caus th? Yes 2 1
tal Rection: The l	5				261	Place of Death (Cl		140	100
Vital Rec ysician; The his certificate director, page	Ba B	25. Was case referred to me examiner?	Heavital	patient 2 🗸 EF	R/Outpatient 3 DOA	Other:		Residence 6	Other:
Division of Vital Records, tal or Attending Physician: The law requirers after death.  To a Director: After this certificate has been simpled in by the funeral director, page 2 should be led in by the funeral director, page 2 should be	-	1 Yes 2 No 27. Manner of Death	28a. Date o		3b. Time of Injury 280	. Injury at Work?	l l	now injury occurred	
on on ath.	ja		Pending			Yes 2 N	1		D. J. D. J. N. Sha
visi or Att frer de Directo	Certification:	3 Suicide 6	Could not be 28e. Place	of Injury - At home	e, farm, street, factory, of	fice building, etc.	28f. Location (S or Town, S		or Rural Route Number
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the:		4 Homicide	determined (Specify)  ng Physician: To the best	of my knowledge,	death occurred at the tir	ne, date and place	e, and due to the caus	e(s) and manner as	s stated.
the H thin 24 the F	Medical	(Check only one) 2 Medical	ng Physician: To the best Examiner: On the basis of and manner st	f examination and	or investigation, in my of	oinion, death occu	rred at the time, date	and place, and dec	
<b>-</b> 20 kir	ğ	29b. Signature and title of ce	ertifier		4	icense number	OCME	September 1	(Month, Day, Year) 5, 2009
		Theday	Mr. Kid	JR. 1	va al	D.C.M.E.	- 01116	Coptombor	
_		30. Name and address of per Theodore M. King		of death (Item 2: nt Medical Ex	^{3a)} aminer 111 Pen	n Street, Balt	more, MD 2120	1	
		· IDOOGOTO IVI KIDO	. שו ועוש. אסטוטום	gistrar' Signatu					

DHMH 17 Rev 1/2001 O'CME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Day

Year

1. Decedent's Name (First, Middle, Last)

	•	For State Registrar	Otato of Ivit	ai yiai io		tificate of l	Death		Reg. No.	2001	0110
Physicia	,	1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month	ath Day	Year	3. Time of Death
/Medica		PETER F. BROV						9	100	09	1407 M
Examine	er	4a. Facility Name (If not institution, g	1 ,	And	10.0	4b. City, Town, or	Location of Death	1	4c. Cc	HI Camb	
Funeral		TENIN SULA RAGIONA 5. Social Security Number 6.	Sex 7. Ag	e (In yrs. la	st birthday)	If Under 1 Year	If Ungler 24 Hrs.	8. Date of Bir (Month, Da	rth	9. Birth	place (State or Foreign
Director	ļ	022-20-6429	1 <b>X</b> M 2□ F	81	Yrs.	Months Days	Hours Min.	11-2-1	927	MAS	SACHUSETTS
land ow it		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
Mary a-f sh	넎	DELAWARE SUSSEX			OCEAN	VIEW					1∭Yes 2□No
with the	Dire	10e. Street and Number  3 WINDMILL LANE				10f. Zip Code 1997(	)		10g. Citize	n of What Cou S	untry?
Irs a	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1			√as Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		Race - Amer Black, White pecify:	
"natura	Completed	15. Decedent's (Specify only highest g	Education irade completed)		(Give H	ent's Usual Occup kind of work done of NOT use retired	durina most of wor	king	16b. Kind	of Business/li	ndustry
within jiene.	omo	Elementary/Secondary (0-12)	College (1-4or 5	5+)			NTENANCE	MAN	HOTE	L	
uld be filed within 72 ho Aental Hygiene. rked other than "natu tic event, the Medical	To Be C	17. Father's Name (First, Middle, La. EMANUEL A. BROWN	st)				18. Mother's Nan	ne (First, Middle C. THOM		ırname)	
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "n, any injury or other traumatic event, If a Medionice.		19a. Informant's Name/Relationship LAURA BROWN/ DAU			3 WINI	DMILL LAI	and Number or Ru NE, OCEAN				
Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition  1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of C	cify)			sition (Name of latory or other place IEAVEN CI		Date -2009		ation - City or T	own, State
permit. Depart Import any inj		21. Signature of Edneral Service Lice	Melson		ME1 43	Name and Addre LSON FUNI THATCHEI	ess of Facility ERAL SERV R STREET	ICES,LT	D ORD,	DE. 19	945
Physician /Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each li	ne. <b>MAIC</b>	chus		ng, such as cardiac		arrest,		Approximate Interval Between Onset and Death
executed an and rial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a conseque	ence of):	مرا					
rtificate be ng physicia as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 Fetal	death 3	Ectopic pregnanc	ey		23	d. Date of deli Month	ivery Day Year
quires that to signed by	þ	Part II. Other significant conditions	contributing to death b	ut not resul	Iting in the un	derlying cause giv	en in Part I.				the cause of death?
sician: The law requir certificate has been si rector, page 2 should l	Completed							24a. Was auto perf 1 □Yes	s an opsy ormed? 2 2 10	24b. Were au prior to d death? 1 □ Yes	topsy findings available completion of cause of
sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			t 3 DOA Oth	26. Place of Dea				
Physer this eral di	.T	1 ✓Yes 2 ☐ No  27. Manner of Death	28a. Date of Inju	ıry	ER/Outpatien 28b. Time of	28c. Injui	T INGISHING I	lome 5 ☐ Res 28d. Describe			cify)
nding ath. r: Afte e fune	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigat	ion 8 LS of		Injury 2400		k?  Yes 2 ⊒No	F	all		
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	building, et	ury - At hor c. (Specify	me, farm, stre	eet, factory, office		City or To	wn, State)		ıral Route Number,
pital o		29a. Certifier Certifying	Physician: To the best			way ) to				and manner as	(Mi ) how
e Hos 124 hc e Fun letely	Medical	(Chack offix 2 Medical Ex	aminer: On the basis of and manner st	of examinat	ion and/or inv	vestigation, in my	opinion, death occ	urred at the time	, date and p	place, and due	to the cause(s)
To the within To the comp	Me	29b. Signature are the of certified	6			29c. Licens	se number		29d. Date	signed (Monti	
			to completed cause of of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought of the Atthought o	500	<u> </u>	200	53361		4	7-16-201	59
BA10		30. Name and address of person wh	no completed cause of c	eath (Item	23a) (Type, I	Print)	dalall 1	- 111	Ilhians	in h	
Stat	e.	CNIS SNJOB, M.E. 31. Date filed (Month, Day, Year)	7 AMANUMA /	rar's Signat	ure 1.0	. 100 8	CHITCH 5	1. 844	Sour	MO	
Registra		SEP 16	2009	4	A. 60	ake					

State of Maryland / Department of Health and Mental Hygiene 2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9 13 **Physician** Phillip Edward Brittingham 2009 6:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 8124 Shire Drive Berlin Worcester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 9 / 28 / 194 / 194 | Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 61 217-44-1439 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location show 10a State 1 □Yes 2 No d other than "natural", or items 23a or 28a-f sl event, it w Medical Examiner must be notified Director MD Worcester Berlin 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 8124 Shire Drive 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify. Specify: þ white 3 ☐ Widowed 4 🗷 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event. It is Supervisor Dept. of Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Edward Brittingham Frances Dinges 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Brittingham/daughter 8117 Worcester Hwy., Berlin, MD 21811 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Riverside Cemetery 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/17/2009 Libertytown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Rectal Corcinomo Immediate Cause (Final 8 years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 Vescular scerduit 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an s certificate has b irector, page 2 s autopsy performe performed? 1 □Yes 2 No Hospital or Attending Physician: after death.

Director: After this certific

in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dic completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00014314 P. KLUG. 100 & Could 8that Solisbury, mo. 2801 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANPIT DN 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Denver B. Sarke Registrar

			For	State	of Marylan		rtment of H		lental Hy	giene		
			Registrar			Cer	tificate of L	Jeath 		Reg. No.	211119	
	Physicia	an	Decedent's Name (First, Middle P.O.G.T.F.)		nı	200776			2. Date of De Month SEPTEM	Day	4 2009	3. Time of Death 10:16 P M
	/Medic		ROSIE  4a. Facility Name (If not institution	ELLA		ROOKS	Alt City Town or	Location of Death	SEFIER		ounty of Death	10:16 P.
	Examin	er	MANOR CARE 1	_	-	1	LARGO	Location of Death			INCE GEO	RGE 'S
~	Funeral		Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th Vear	9. Birthp	ace (State or Foreign
	Director		217-30-4017	1 □ M 2 □ XF	90	Yrs.	Months Days	Hours Min.	(Month, Da MARCH	26 19	919 MARY	
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Loc	eation				110	Od. Inside City Limits
	Aaryle f sho	or										1∭Yes 2□No
	the N	Director	MD PRINC:	E GEORGE'	S   M.	ITCHELL	VILLE 10f. Zip Code			10g. Citizer	en of What Coun	try?
:	3a or		2005 MITCHELLY	VILLE ROA	D		20716			USA		
	death	Funeral	11. Marital Status		edent Ever in U.	.S. 13. V	Vas Decedent of H	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No	- 14.	I. Race - Americ	
Š.	or ite	y Fu	1 Never Married 2 Marr	ried 1 ∏Yes If Yes. G	2 <b>X</b> No		☐Yes 2 No	Specify:	Tilodii, Cto.,		Black, White, e BLA	
9500-612	ural",	d by	3 Widowed 4 □ Divorced	Year or I		10. D						
<u>ဂ</u>	in 72 "nair Redica	olete	(Specify only highe			1 (Give I	ent's Usual Occup kind of work done o O NOT use retired	luring most of work	ing	TOD, KING	f of Business/Ind	ustry
717	illed within 72 hours after death with the Maryland Hygiene. Hhan "natural", or items 23a or 28a-f show ther than "natural", or items 23a or 28a-f show ent, the medical Examinar must be notified at	Completed	Elementary/Secondary (0-12) 10TH	College (	(1-4or 5+)	1	MESTIC	,		PRIV	<b>VATE</b>	
_		Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nam			,	
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ค์ .	Heal Heal tem 2		20a. Method of Disposition		20b. F	lace of Dispos	sition (Name of		Date	20c. Loca	ation - City or To	wn, State
Ê,	Pages nent o int: If i		1 🕅 Burial 2 □ Cremation 4 □ Donation_ 5 □ Other (S				atory`or other plac CEMETERY	9/2	1/2009	LANDO	OVER, MAR	YLAND
Baitimore,	permit. Yages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service	Licensee			Name and Addres	,			S FUNERA	L HOME 20785
			23a. Part1. Enter the disease, or	complications that	caused the deat			VER ROAD g, such as cardiac			KILAND_	Approximate
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	/Medical		disease or condition resulting in death)	Due to	ASTATIC (or as a conseq		CANCER					
	xaminer	-	Sequentially list conditions,	b. ANE	ALA (or as a consec	anne de						
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o j	y the atter	ysic	1 □ Yes 2 √ No 9 □ Unknown	9 🗆 Unk		deam 5∟	Other (specify)					
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Las	requires man ween signed b nould be deta	ed by							1 🗆	Yes 2□	No 3□ Prob	ably 4 Unknown
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0	rnysician: this certific ral director,	၉	1 ☐ Yes 2 ☐XNo		Inpatient 2			4 EL Nursing H			☐Other (Specif	y)
	aling h. After funer	tion	27. Manner of Death  1 X Natural 5 ☐ Pendir 2 ☐ Accident investi	g (Mo	e of Injury nth, Day, Year)	28b. Time of Injury	28c. Injur Work M 1 🗆	yat (? Yes 2 □ No	28d. Describe	now injury o	occurrea	
DIVISION	after death.  Director: After In by the fune	ifica	3 ☐ Suicide 6 ☐ Could	not be	e of Injury - At he	l ome, farm, stre	et, factory, office				Number or Rura	l Route Number,
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1	withir To th comp	Me	29b. Signature and title of certifie	sild.	1	10	29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
	ä		100		/ (11		D6665	58		SEPTE	MBER 16	, 2009
	トイ		30. Name and address of person REXFORD BA	ABILAH M.	D. 7500	HANOVE	Print) R PARKWAS	SUITE 1	01A GRE	ENBEL	T,MARYL	AND 20770
£	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 1 7 2009	Beneva 32.	Registrar's Signa	arks						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ate c Month 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 09 09 A M 09 2:30 Joseph Beal1 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Alice Manor Nursing Home Baltimore Date of Birth (Month, Day, Year) 9-05-1935 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Baltimore, MD 214-32-9117 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2095 Rockrase Avenue 21211 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 📆 🖠 o Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Parts Manager Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John C. Beall Bessie Burke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Mease, Sister 1794 Holladay Street, Gambrills, MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/10/2009 Atlantic Crematory Glen Burnie, MD 21. Signature of Fun 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conservence of): Sequentially list conditions, if my cause immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Triknown

**Physician** /Medical Examiner Examine

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

MD

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked of the than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is any hijury or other traumatic event, it is any event.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transil the signed by tl I be detach≀ page 2 s this certificate

Physician/Medical

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Completed

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Certification:

Medical

The law requires that the death certificate be executed

Hospital or Attending Physician:

death.

after

24 hours e Funeral

within 2 To the

eral Director: After th filled in by the funeral

P.O. Box 68760.

of Vital Records,

Division

resulting in death) Last IF FFMALE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ∐ Yes 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

2 🗆 No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ 110

27. Manner of Death

1 Wafural

2 Accident

3 Suicide

4 Homicide

determined

28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation 6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier

Hospital:

1 ritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number D 31464 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD, 821 N. ENTAW ST SINTE 30 8 BALTIMORE MD A. ith & HMI

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

and manner stated.

		Please	Type or Prin					All Copies Mental Hy		_		
		For State Registrar	State of Ivi	ai yiaii		ficate of		-	Reg. No		2.1	101
		Decedent's Name (First, Middle, La	ist)					2. Date of De	_		3. Time	of Death
Physicia /Medic		Genevieve	Marie		Clark			9'	20	h 09	175	M
Examin	er	4a. Facility Name (If not institution, gin	ve street and number)	NOTH	O/CEM 1	b. City, Town, o	Location of De	ath	49	County of Deat	h Dalle	
Funeral		5. Social Security Number 6.		e (In yrs.		f Under 1 Year Months Days	If Under 24 H	rs. 8. Date of Bir	th	9. Birt	untry)	te or Foreign
Director		215-26-7060 Usual Residence of Decedent	1□M 2□₹	79	Yrs.	Nontris Days		n. (Month, Da	9, 1	929	MD	
yland how		10a. State 10b. County		10c. Cit	y, Town or Locat							City Limits
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with the	Funeral Director	10e. Street and Number 730 Furnace St	reet			10f. Zip Code	21502	,	10g. Cii	tizen of What Co USA	-	
death	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13. Wa	s Decedent of H		(Specify Yes or No erto Rican, etc.)	)-	14. Race - Ame Black, White	rican Indian	
s after , or ite	y Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 □	No	1	es, specify out ]Yes 2 <b>□X</b> o	Specify:	ono moun, oto.,		0	white	
2 hours	Be Completed by	15. Decedent's E	Year or Dates: ducation		16a. Deceder	nt's Usual Occup	ation		16b. K	ind of Business/		
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2 shou and N is mar aumat		19a. Informant's Name/Relationship						Rural Route Numb			Zip Code) GA 3	1212
l and dealth		Kenneth Clark  20a. Method of Disposition	SOI			Sharon		Date	esv	ocation - City or		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Evaning must be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		Su	lace of Dispositi emetery, cremai nset Men	ory or other place norial Park	ce)	9/25/200		Cumberl		MD
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		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each li	the deathne.	n. Do not enter	the mode of dyi	ng, such as card	liac or respiratory a	rrest,		Approxir Interval I Onset ar	nate Between nd Death
Physician /Medical		disease or condition resulting in death)	a. UROS Due to (or as	a consequ	SS Jence of):						2	DAYS
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Physic this o		1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpati		ER/Outpatient 28b. Time of		4 LI Nursin	g Home 5 Res			cify)	
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pital o		29a. Certifier 1 Certifying P	hysician: To the best				mo data and pl	and due to the	2 221100	c) and manner a	e etatod	
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical		miner: On the basis of and manner st	of examina								e(s)
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21		30. Name and address of person who ROBUSTIPNO BR					ngziAL K	ME Cur	MRDD	i Ann n	10 2/	SOA
Sta	te	31. Date filed (Month, Day, Year)	3. Registr	ar's Signa		- 7	-, -, -, -, -,	, - , (,0)	. 100	UIVU, IV	1001	
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Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Vear Eugene Clark SEPTEMBER 14 2009 12:09P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Reeders Memorial Home Boonsboro Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) 1 ☑ M 2 🗆 F Director 578-40-5567 85 Jan. 28, 1924 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examinator must be notified at Director 1 ☐ Yes 2 🕅 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19505 Windsor Circle 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Herbert James Clark Elizabeth Genevieve Poplar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Douglas Clark/Son 10604 Hershey Dr., Williamsport, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 9/18/2009 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complication; that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cauth on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Merasleyi **Physician** Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atco artholis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **A After this certificate has been signed by the attending physician and physician and s the burial-tran Due to (or as a consequence of) Physician/Medical attending p If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔼 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 s 24a. Was an autopsy performed 2 X No 2 **V**No 1 ☐ Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2M2No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 🛍 Natural 5 Pending ours after death. investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 91 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713 301-432-8470 QADIR, 32. Resistrar's Signature

State Registrar

DHMH 17 Rev 1/2001

21215-0036

altimore, Maryland

Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 14 2009 7:50 P James Allen Clopper September /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner Homewood At Williamsport Williamsport Washington County 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F Months Days Hours 212-14-7538 Director 2,1915 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, The Medical Evant Inc. or other traumatic event, The Medical Evant Inc. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County Director 1 ☐Yes 2 No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 U.S.A. 18506 Breeze Hill Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify 3 White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Engineering Aircraft Mfg. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lydia Virginia Hornbaker Clopper ၉ Charles Finley Clopper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Finlay-daughter 3 Lori Ct. Reading, PA 19606 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or conce. Burial 2 Cremation 3 Removal from State Blairs Valley Cemetery 9-19-2009 Clear Spring, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A, Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the Bease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fullure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Preumonia disease or condition resulting in death) 1 dai /Medical Due to (or as a consequence of): Examiner Kronic Obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐Yes 2 ☐No funeral director. 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No s after death. 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a

To the Funeral C Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number September 15, 2009 Kuttrer Sands no D47451 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nursing Home, 16505 3H-L Cynthia Kuttner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 6 2009 Registrar

3. Time of Death

1152

NY

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Co. General Cedar La Columbia MO 21044

1 ☐ Yes 2 XNo

of Vital Records. **Division** ours after death.

To the Hospital within 24 hours a To the Funeral C 100 122

State Registrar

Medical

Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Haward 31. Date filed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be

determined

cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

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# Baltimore, Maryland 21215-0036

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Box 68760,	ath certificate be executed	utending physician and or use as the burial-transit

Division of Vital Records, P.O. B

		Please Type or State o	<b>Print in Black Ir</b> f Maryland / Dep					le.	
	•	For State Registrar		rtificate of			73 75	19 3	1196
		Decedent's Name (First, Middle, Last)				2. Date of Deat Month		(ear 3. T	ime of Death
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Examin		4a. Facility Name (If not institution, give street and number of the street)		4b. City, Town, o	r Location of Death		4c. County of	Death	
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Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday 92 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	Country)	state or Foreign
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8 3 <b>1</b> 8 8		Kutasillo mo	1284 3	035 01d W	ashington	Rd. Wa	ldorf, M		
		23a. Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on e	aused the death. Do not eleach line.			1	4	Appre	oximate val Between **and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	ALOSCLER	2776	MADO	ASLVI	AL D	LISAT 8	
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-4	er	Sequentially list conditions, bb	(or as a consequence of):					F	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the bur		29a. Certifier  (Check only 2 Medical Examiner: On the							
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086		30. Name and address of person who completed cause	12070 00	1 LINE	CEATER	WALDO	F, Au	10 20	3602
Sta Registr		31. Date filed (Month, Day, Year) 32. F SEP 1 5 2009	Registrar's Signature	parker			/		
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		1	For State Registrar		-	Certificate of		Re	g. No.	
Physi	iciar		1. Decedent's Name (First, Middle, Las Robert Gordon					2. Date of Death Month	Day Year	3. Time of Death 8:51 P M
/Med Exam			4a. Facility Name (If not institution, give	e street and number)			or Location of Death	<u>Septembe</u>	r 11, 2009 4c. County of Deat Wicomic	h
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permit. Pages Department of Important: If II any injury or or	SUCE.		21. Signature of Funeral Serv el cen	na CF	P	22. Name and Add Holloway 501 Snow	ress of Facility Funeral H Hill Rd.,	ome Profe Salisbu	essional A cy, MD 218	ssociation 04
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g physical as the b	100	Medical		d						
he death cer the attendin	Maciologica	riiysicialiyiy	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	ncy		23d. Date of de Month	livery Day Year
requires that the signed by rould be detacted.	Ì	2	Part II. Other significant conditions of	ontributing to death but	not resulting in t	he underlying cause g	iven in Part I.		acco use contribute to s 2 No 3 □ P	o the cause of death?
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hirurs after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	, dumo	combieren						24a. Was an autopsy perform 1 □ Yes 2	prior to death?	utopsy findings available completion of cause of 2 2 No
sician certifi rector	á	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		07.004	ther:	th (Check only one		
ding Phy h. After this funeral d	- 15	- : -	27. Manufer of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day,		me of ury 28c. Inj	4 Li Nursing n	28d. Describe ho	nce 6 □ Other (Spe w injury occurred	
al or Atter s after dea il Director ed in by the	Cottoo	S I III Co	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farn (Specify)	n, street, factory, office	,	28f. Location (Str City or Town	reet and Number or Ri , State)	ural Route Number,
ne Hospit n 24 hours ne Funera		ealcal		ysician: To the best of niner: On the basis of a and manner state	examination and					
To th within To th comp	M		29b. Signature and title of certifier			i	nse number	29	9d. Date signed (Mont 9-14-0	
3 mg			30. Name an address of person who				SKUSRUR	x mo	21804	
S Regis	State strai		31. Date filed (Month, Day, Year)	32. tegistrar	's Signature	faces		, ,		

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Year

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits 1 ☐ Yes 2 No

Approximate Interval Between Onset and Death

Year

Day

3 Probably 4 Unknown

Month

Maryland

white

2009

2:05 AM

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) Day -Month **Physician** James Moses Carlisle 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Coastal Hospice at the Lake Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, July 29, 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 2 M 2 □ F Yrs 221-12-6111 86 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural" -- " any injury or other traumatic event." 10a. State 10b. County 10c. City, Town or Location Director MD Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29535 Waller Road 21875 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Builder Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willard Carlisle Anna Mary Hastings ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Nephew) 29441 Waller Road Delmar, MD 21875 John Sparrow 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 09-12-2009 4 ☐ Donation 5 ☐ Other (Specify) Delmar, Delaware 22. Name and Address of Facility
Short Funeral Home
13 East Grove Street 21. Signature of Funeral Service Licensee Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ROSTAT Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 - Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 □ Yes 2 □ No Completed 24a. Was an autopsy performe 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2√ZNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation Accident Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number DO05 8410

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WAR

15

HULAM 31. Date filed (Month, Day, Year)

SEP

24b. Were autopsy findings available prior to completion of cause of death? Other: 4 Nursing Home 5 Residence State (Specify) Hespica 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

t mt IVA

State Registrar

DHMH 17 Rev 1/2001

BOX 1733

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Charles Byard Carey 14 2009 5:24 a September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Cecil Elkton If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ▼ M 2 □ F Director 74 222-20-6119 DE August 12, 1935 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the "Modical Examinating must be notified at 1 ☐ Yes 2 No Director Elkton Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 81 Hunter Ct. 21921 **USA** Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No þ 3 Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Accountant Accountant Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account Account 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Arthur Russell Carey Mary Elizabeth Porter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan G. Carey/Wife 81 Hunter Ct., Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) North East, MD September 26, 2009 North East Methodist Cemetery 22. Name and Address of Facility Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): poro bother Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical by the attending partached for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown BPH. .24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 s autopsy After this certificate har funeral director, page 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: t☐Inpatient 2☐ER/Outpatient 3☐DOA Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 0063730.

State Registrar

31. Date filed (Month, Day, Year) SEP 1 6 2009

VAMITA

32. Registrar's Signature

UNION

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TUNI

40SPITAL,

					artment of Health and		
			For State C Registrar		rtificate of Death		g. No. 2000 2000
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Dav Year
-	/Medic		Gary Alan Daigle, Sr.		4. Oh. Turn and section of Doct	Septemb	er 12, 2009 6:40 P M 4c. County of Death
	Examin	ier	4a. Facility Name (If not institution, give street and no 21021 Goshen Road	imber)	4b. City, Town, or Location of Deat Caithersburg	n	Montgomery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs	8. Date of Birth (Month, Day,	
	Director		016–40–0113 ^{1໘ м 2□ F}	60 Yrs.	Months Days Hours Min.	Apr 3,	1949 Massachusetts
	land ow t		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Mary a-f sh	tor	MD Montgomery	Gaithers	ourg		1 ☐ Yes 2 X No
	or 28	Funeral Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Country?
	s 23a	eral	21021 Goshen Road	- dd	20882		SA  14. Race - American Indian,
(0	fter de ritem inert	Fun	Armed F	2 □ No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	to Rican, etc.)	Black, White, etc.
5-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be portified at		3 ☐ Widowed 4 ☐ Divorced If Yes, G Year or I	ive Dates:1969-72	1 ☐Yes 2X No Specify:		Specify: White
15-(	"natu	Completed by	15. Decedent's Education (Specify only highest grade completed)	) (Give	edent's Usual Occupation Is kind of work done during most of wor DO NOT use retired)	rking	6b. Kind of Business/Industry
2121	filed withir Hygiene. other than ent, the M	dmo	Elementary/Secondary (0-12) College 2	(1-4or 5+) Owner	*	(	Construction
br	12 should be filed w h and Mental Hygie 7 <b>Is marked other</b> th traumatic event, th	Be C	17. Father's Name (First, Middle, Last)			me (First, Middle, M	laiden Surname)
ylaı	Suld by Ments arked aric e	10	Harvey Daigle		Lorraine		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, fire Medical Exprinser must be nodified at		19a. Informant's Name/Relationship (Type. Print)  Gail M. Daigle/wife		ng Address <i>(Street and Number or Ri</i> <b>I Goshen Road Gai</b> t		
	ges 1 and 2 it of Health it If item 27 li or other tra	-3	20a. Method of Disposition		osition (Name of matory or other place)		20c. Location - City or Town, State
altimore,	Pages nent of nt: If i		1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		urney Crematory 09	9/16/09 1	Woodbine, MD
alti	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licenses	// G	2. Name and Address of Facility Ding Home Crematio	on Service	e P.O. Box 784 Clarksville, MD 21029
B	65 20 2		Devaly I. Hell				
			23a. Part 1. Enter the discase, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final	each line.		c or respiratory arre	Onset and Death
	Physician /Medical		disease or condition a. Metal	static Maligna (or as a consequence of):	ant Melanoma		/ years
	Examiner	,	Sequentially list conditions b.				
	red isit	inei	Sequentially list conditions, Due to cause. Enter Underlying Cause (Disease or injury	(or as a consequence of):			
,	te be executed /sician and e burial-transit	Examine	that initiated events c.	(or as a consequence of):			
760,	ate be nysicia ne bur	[a]	d				
89 x	leath certificate attending physic	Physician/Medi	IF FEMALE:				
Вох	attend for us	cian/	in the past 12 months?		☐ Ectopic pregnancy ☐ Other <i>(specify)</i>		23d. Date of delivery  Month Day Year
P.O.	t the d by the tached	hysid	1 Yes 2 No 9 Unknown				
	res that signed I be deta	by P	Part II. Other significant conditions contributing to	death but not resulting in the u	inderlying cause given in Part I.		acco use contribute to the cause of death?
ord	w require been signatured is					1 □ Ye	s 2 X No 3 ☐ Probably 4 ☐ Unknown
of Vital Records,	The law cate has t	Completed	***			24a. Was ar autopsy perform	prior to completion of cause of
tal	ian: Th rtificate tor, pag		25. Was case referred to medical		26 Place of De	1 ☐ Yes 2 ath (Check only one	! Mo 1 ☐ Yes 2 ☐ No
f Vi	nysician: vis certific director,	To Be	examiner?	Inpatient 2 ER/Outpatie	T Others		nce 6 Other (Specify)
	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Mo	e of Injury 28b. Time of Injury	Work?	28d. Describe ho	w injury occurred
Division	vttendi death. ctor: A y the fu	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place	e of Injury - At home, farm, st	M 1 ☐ Yes 2 ☐ No	28f. Location (Str.	reet and Number or Rural Route Number,
<u>S</u>	al or At s after d if Direct ed in by	Certification:	4 Homicide determined built	ling, etc. (Specify)	,	City or Town	
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the				th occurred at the time, date and place		ause(s) and manner as stated. ate and place, and due to the cause(s)
	thin 2, the F	Medical	one) and ma 29b. Signature and title of certifier	nner stated.	29c, License number	25	9d. Date signed (Month, Day, Year)
	F 8 5 0		D 1A		D5248		eptember 14, 2009
	uni		30. Name and address of person who completed cau	use of death (Item 23a) (Type,		•	•
	Ug^		David H. Plotkin, M.D.	18111 Prince I	Philip Dr. Suite 3	304 Olney	MD 20832
	Sta Registr	te ar	31. Date filed (Monts Day Year) 6 2009 32.	news 8.	barke		
				- 4	<del></del>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		State of Ma	aryland .		tificate of			Reg. No.	2009	31201
Ph	ysicia	ın	1. Decedent's Name Vincent		Dameron,	Sr.				2. Date of Dea Month	Day	Year	3. Time of Death
/ſ	Medic amin	al -			re street and number)			4b. City, Town, o	r Location of Death	Septem		1, 2009 ounty of Death	6:40 P ^M
	amm	51	4507 Cle	_				Silver	Spring		Mon	tgomery	
Fun	eral		5. Social Security N	umber 6. S		e (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	Count	
Dire	ctor		219-12-99 Usual Residence of	998	A	86	Yrs.			Aug 4,	1923	Virg	inia
yland	at at		10a. State	10b. County		10c. City, T	Town or Loc	ation				10	d. Inside City Limits
e Mar	titled	ctor	MD	Montgome	ery	Silve	r Spr	ing					1 □Yes 2 X No
ith the	ou ag	Director	10e. Street and Nur		7			10f. Zip Code				en of What Count	ry?
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. then "natural", or items 23a or 28a-f show	event, the Medical Examinar must be notified at	Funeral	4507 Cle	arrield i	12. Was Decedent I	Ever in ILS	13 V	20906	lisnanic Origin? (Sn		USA 14	. Race - America	ın Indian.
of item	oliner		<ol> <li>Marital Status</li> <li>Never Marri</li> </ol>	ed 2 X Married	Armed Forces?  1 XYes 2 1  If Yes, Give				lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, White, e	tc.
5-0036   72 hours aft "natural", or	Exa	d by	3 🗆 Widowed	4 Divorced	If Yes, Give Year or Dates:	1942-4	5 '	□Yes 2XINo	Specify:		S	pecify: White	9
5-(   72 h "natu	dicel	letec	(Spec	15. Decedent's E	ducation ade completed)	1	16a. Deced	ent's Usual Occup	nation during most of work d)	ing	16b. Kind	of Business/Ind	ustry
withir iene.	he M	Completed	Elementary/Seco	ndary (0-12)	College (1-4or 5	i+)	Machi		4)		Elec	tronics	
filed all Hygin	/ent,	Be	17. Father's Name			1			18. Mother's Name			urname)	
arylan should be ind Mental	atic e	2	Edward G	. Dameron	ו				Della Be	II Neth	eary		
Aar 2 sho n and	, a		19a, Informant's Na					•	and Number or Rur				
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Baltimore, Maryland 2121 Dermit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Moordant: If item 27 is marked other than 1	ury or c		1 ☐ Burial 2		Removal from State fy)	Fina	etery, crem 1 Jou	sition (Name of latory or other place rney Cre	matory 09	/15/09	Wood	bine, M	)
Balt permit. Departr Importa	any Injury or one once.		21. Signature of Fu	ineral Service Lice	1/ OH	MO12	GO GO	Name and Addre	ess of Facility Crematio	n Servi	ce P	0.0. Box	784 MD 21029
Physic			23a. Part 1. Enter the shock, or hea Immediate Cause (disease or condition resulting in death)	rt failure. List only (Final	plications that caused one cause on each ling Type II	the death. ne. Diabe	Do not ente						Approximate Interval Between Onset and Death
/Med Exam			rooding in doding		Due to (or as Vascula)								
		Jer	Sequentially list con	nditions,	b. Due to (or as							- 3	
scuted	transit	Examiner	cause. Enter Unde Cause (Disease or that initiated events	3	c. Atrial 1			n		_			
68760, ificate be executed physician and	the burial-transit		resulting in death) l	Last	Due to (or as	a consequer	100 01):						
	as the	ledical			u				-5/32		1		
I Records, P.O. Box The law requires that the death cerl ate has been signed by the attendin	tached for use as	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □ 9 □ Unknown	months? □No	23c. If yes, outcome  1  Live birth 4  Pregnant a 9  Unknown	2 Fetal de	eath 3	Ectopic pregnand Other (specify)	су		23	3d. Date of delive Month	ry Day Year
s that the	e detac	by Ph			contributing to death b	ut not resultir	ng in the ur	derlying cause giv	en in Part I.	23e. Did t	obacco use	e contribute to th	e cause of death?
Vital Records, sician: The law requires the certificate has been signed.	should be deta									1 🗆 '	res 2	No 3 ☐ Prob	ably 4 🗌 Unknown
ecc law re		Completed								24a. Was	osv	24b. Were autor	psy findings available inpletion of cause of
	pag	Con								perfo 1 □Yes	rmed? 2X No	death? 1 □Yes	
Vita Ilclan: certifi	rector, page	Be	25. Was case refer examiner?		Hospital:			Ott	26. Place of Deat				
Of Phys	eral dir	5.T	1 ☐ Yes 2 🔀 27. Manner of Deat		28a. Date of Inju	ent 2 EF	R/Outpatien 8b. Time of	t 3 DOA 28c. Inju	4 LI Nursing no	ome 5 Resi		Other (Specify occurred	′)
ion Inding It: Afte	e fune	atior	1 X Natural 2 ☐ Accident	5 ☐ Pending investigatio	n (Month, Da	y, Year)	Injury		'kí? ]Yes 2 □ No				
Division of I or Attending Physafter death. Director: After this	in by th	ertification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	Zoe. Flace of Inj	ury - At home c. <i>(Specify)</i>	e, farm, stre	eet, factory, office		28f. Location (: City or Tox	Street and vn, State)	Number or Rura	Route Number,
Division of Vita vita to the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific.	tely filled	edical C	29a. Certifier (Check only	1X Certifying P 2☐ Medical Exa	hysician: To the best miner On the basis of	of examination	edge, death n and/or in	occurred at the treatment	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) a	and manner as si place, and due to	tated. the cause(s)
o the	ејфис	Med	one) 29b. Signature and	title of pertifiar	and/manner st	ated.		29c. Licens	se number		29d. Date	signed (Month, i	Day, Year)
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Re	Sta egistra	_	31. Date filed (Mon	SEP 16	2009 Sinu			arkel					

		Amend#26PFR PHYState of Maryland / Depressive 9/11/09 AACO CMH Ce	artment of Health and Nortificate of Death	lental Hygie	ene . No. 2011 9 3 202				
Physi /Mo	ician dical			2. Date of Death	Day Year 3. Time of Death 729 7009 10-26 A M				
Exam		As Estite Name (Mark Institution who stands and number)	4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore				
Funera Directo		5. Social Security Number  196-34-8815  6. Sex 1 № M 2 □ F  7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Y	ear) 9. Birthplace (State or Foreign Country) Pennsylvania				
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinat must be notified at once.	ţo	Usual Residence of Decedent  10a. State  10b. County  Maryland Prince George's  Bowie	ocation		10d. Inside City Limits 1 X Yes 2 ☐ No				
	ral Directo		10f. Zip Code 20715	_	i. Citizen of What Country?				
036 urs after dea al", or items	by Fineral	3 Widowed 4 □ Divorced If Yes, Give Year or Dates; 1961–66	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White				
Baltimore, Maryland 21215-0036 permit. Pages I and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, The Medical Evanniang Injury or other traumatic event, The Medical Evanniang	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 College (1-4or 5+)  Compu	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired) ter Programming	ng	ib. Kind of Business/Industry Federal Government				
and and and and and and and and and and	Be C	17. Father's Name (First, Middle, Last)		(First, Middle, Ma	, and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second				
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imore, Pages 1 a ment of He ant: If item		20a. Method of Disposition  1 ABurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition cemetery, cre Resurrect	inatory or other place) Lion Cemetery 9/4/2	2009 C1	c. Location - City or Town, State inton, Maryland				
Balt permit. Departi Imports any Inji	ouce		2. Name and Address of Facility Rol 6000 Annapolis Roa		vans Funeral Nome, — , Maryland 20715				
Physicia /Medica Examine	al	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Approximate Interval Between Onset and Death  Onset and Death							
THECOIDS, P.O. BOX 68/60,  The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	edical Examiner								
	Physician/Medi		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year				
cords, P. w requires that the speed signed by should be detailed.	2	Part II. Other significant conditions contributing to death but not resulting in the c	underlying cause given in Part I.		cco use contribute to the cause of death?  2  No 3 Probably 4 Unknown				
	Completed			24a. Was an autopsy performe 1 □Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No				
on of	Certification: To Be	examiner? 1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	ont 3 DOA Other: 4 Nursing Ho of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how 28f. Location (Stree	et and Number or Rural Route Number,				
DIVISION To the Hospital or Attentivitin 24 hours after death To the Funeral Director:			th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau	ise(s) and manner as stated.				
To the within 2 To the complet	Medical	29b. Signature and title of certifier  illuma A Buttan	29c. License number	290	1. Date signed (Month, Day, Year)				
IOTIC	A	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) OLD COURT	ro lan	dallstown MD				
S Regis	State strar	31. Date filed (Month, Day, Year) SEP 1 0 2009 32. Redistrar's Signature	park						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Edward E. Ellingsworth 2009 10 /Medical 4c. County of Death . 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NICOMICO 59/1564M YENINSUNG CONIL If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 😾 M 2 🗆 F Min. Months Days Hours 76 222-18-9787 Director 4-12-1933 Easton Maryland Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b County show Ħ 1 ☐ Yes 2 XNo Director ir than "natural", or items 23a or 28a-f s the Medical Examiner must be motified DE Sussex Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19956 USA Completed by Funeral 30250 E. Trap Pond Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No White Baltimore, Maryland 21215-0036 Specify: Specify: 3 ☐ Widowed 4 🏅 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) ould be filed within College (1-4or 5+) Painting Painter Health and Mental Hygi em 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Gilbert Pages 1 and 2 should Fred Ellingsworth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health a Important: If item 27 is 30250 E. Trap Pond Road Laurel, De. 19956 (Daughter) Donna Riggin 20b. Place of Disposition (Name of cemetery, crematory or other place)

First State Crematory 9-16-2009 20c. Location - City or Town, State 20a. Method of Disposition 6 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Millsboro, Delaware Injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 700 West Street Hannigan, Short, Disharoon F.H. Laurel, Delaware19956 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NEUMONIA. /Medical Due to (or as a consequence of): **Examiner** ·DIFF Sequentially list conditions ner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Centrovanular disease that the death certificate be executed Alunderenone Exami Due to (or as a consequence of): burial Box 68760, physician Physician/Medical attending properties for use as as yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death ☐Yes 2☐No P.0. the 9 Unknown 9 Hlnknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 1 □Yes 2 No 1 ☐ Yes 2 <del>☑N</del>o Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ie Hospital or Attending P n 24 hours after death. ie Funeral Director: After t Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only completely and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 32014 411 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Unitor of of 504 13 salistacy MI> 21804 and 31. Date filed (Month, Day, Year) State 15 SEP Registrar

	_	State Registrar		artment of H rtificate of L		Re	g. No.	1110	3120	
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Carol Ann FORCINO				2. Date of Death Month Sept.	Day	Year	3. Time of Death 8:40p M	
Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4d. County of Death  4d. County of Death  4d. Capter  4d. County of Death  4d. County of Death								
Funeral Director	J.	5. Social Security Number 6. Sex 1	e (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 22		9. Birth	pplace (State or Foreign Intry) ryland	
aryland show dat		Usual Residence of Decedent  10a. State 10b. County  Marran 1 and 1 Usual in a trans	10c. City, Town or Lo						10d. Inside City Limits	
th the M or 28a-f e notifie	Director	Maryland Washington  10e. Street and Number	Boonsbor	10f. Zip Code		10	g. Citizen of	What Co	untry?	
eath wi	Funeral [	18310 Manor Church Road  11. Marital Status 12. Was Decedent	Ever in U.S. 13.1	21713 Was Decedent of Hi	ispanic Origin? (Spe	ecify Yes or No-	14. Ra	USA	ican Indian,	
72 hours after death with the Maryland natural", or Items 23a or 28a-f show ilcal Examiner must be notified at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	No	Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2ሺ No	n', Mexican', Puèrto Specify:	Rićan, etc.)	Speci	ack, White	hite	
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ੂੰ ਦੂ <b>ਵੇਂ</b> ਸ਼੍ਰੇ		10 0	I	Homemaker 	18. Mother's Name	e (First, Middle, N	<u>Her</u> Maiden Surna		ome	
	To Be	Everett L. Smith Dorothy L. Mongan								
nd 2 sho alth and 27 is ma ir trauma		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street					•	
es 1 a of Hea		Clarence R. Forcino - Husl 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place of Dispo cemetery, crer	osition (Name of matory or other plac	ce)	Date 2	20c. Location	- City or		
permit. Pag Department Important: I any Injury o once.		4 Donation 5 Other (Specify) Manor Cemetery 9/18/09 Tilghmanton, Marylar 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740								
Physician /Medical Examiner	j.	Sequentially list conditions b. Lun	NAR 1			est,		Approximate Interval Between Onset and Death  2 HPS  ONE YEAR		
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):								
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2 Mo   9   Unknown   23c. If yes, outcome pf pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (specify)   5   Other (						ate of del Month	ivery Day Year	
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dir dir	은	27. Manner of Death 28a. Date of Inju	28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  28d. Describe how injury occurred Work?						cify)	
To the Hospital or Attending Ph within 24 hours arier death. To the Funeral Director. After th completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)								
Hospi 24 hour Funer etely fills	Medical (								s stated. e to the cause(s)	
To the within To the comple	Mec	29b. Signature and title of certifier 2		29c. Licens					h, Day, Year)	

### 09-06951 Janet Elizabeth Fileter

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

et Elizabetii i		1- For State Certificate of Death	Reg.	No.	3. Time of Death			
Physicia	an/	1. Decedent's Name (First, Middle,Last)	Date of Death  Month  September 5	ay Year 5, 2009	1714 hrs			
edical Exami		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1601 Jersey Road Salisbury		4c. County of Death Wicomico				
Funeral Director		5. Social Security Number 213-64-3744 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth( 05/06/	B. Birthplace (State or Foreign Comaryland				
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If it fit mand Mental Hygiene are or other transmatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Wicomico Salisbury  10e. Street and Number 1601 Jersey Road 21801  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced of Pres, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)  12 College (1-4 or 5+)  13. Was Decedent of Hispanic Origin? (Sperify Cuban, Mexican, Puerto For Dates:  14. Was Decedent of Hispanic Origin? (Sperify Cuban, Mexican, Puerto For Dates:  15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired the man resources  16a. Decedent's Usual Occupation (Give kind of two during most of working life. DO NOT use retired the man resources  17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Robert Norman Hanna 19a. Informant's Name/Relationship (Type, Print) 5563 Watson Rd., Lau	ork done ed)  (First, Middle, Machine Route Number (First)	White, Specify: 16b. Kind of Busi  Perdue aiden Surname)  n Schwat Der, City or Town 19956	American Indian, Black, etc.  white ness/Industry  inc.			
Baltimore, MD wernit. Pages 1 and 2 sh permit. Pages 1 and 2 sh permit. Pages 1 and 2 sh permit of health and injury or other traumant		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State   Salisbury Crematory or other place)  4 Donation 5 Other Specify: Salisbury Crematory   9/11/09   Salisbury, MD    21 Stinature A Funcial Service Licensee   22 Name and Address of Facility Holloway Funeral Home Professional Association   501 Snow Hill Rd., Salisbury, MD 21804    23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Death   Deat						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death entilicate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and the control of the format of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of	Physician/Medical Examiner	X UNPENDED AMENDED 23a,27,28a-f,perME, g896 10/22		23d. Date of Month	delivery Day Year			
	inlefed by	26. Place of Death (Check	1 Yes  24a. Was autor perfo 1 Yes	an 24b.1	ibute to the cause of death?  Probably 4 Unknown  Were autopsy findings available prior to completion of cause of death?  Yes 2 No			
Vital hystcian this cert	TO Be	examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; 4 Nursi	ing Home 5	Residence 6 Other: Scene				
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Own		30. Name and a dress of person who completed cause of death (Item 23a)  Margarita Korell MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201					
	Sta	31. Date filed (Month, Day, Year) 32. Registrar's Signature						
Reg	istr	SEP 15 2009 Lenera D. Janes						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 19,2009 10:48A M Sept. Michelle C. Furr /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Birthpus Country) W York **Funeral** 1 □ M 2 X F New 3,1956 Director 100-52-1657 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f shov ither traumatic event, I've Nacilical Experiment out the confined at 1 XYes 2 ☐ No Funeral Director Maryland Anne Arundel Harwood death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20776 U.S.A. 4488 Owensville Sudley Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: White ۇ م 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Research Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donna J. Brady Joseph E. Paszkiewicz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20776 19a. Informant's Name/Relationship (Type. Print) 4488 Owensville Sudley Road, Harwood, Maryland Mark S. Furr Department of Health Important: If Item 27 any injury or other troonce. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 9-29-09 Lackawanna, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or compocations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) l HR **Physician** OUARDIAL /Medical Due to (o as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ■ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 105158 6131 SHADY SIDE 30. Name and address of poson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Ver

31. Date filed (Month, Day, Year)

TEINFELO

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 22, Year 2009 **Physician** September 5:12 A. M Donnel Eugene Gift /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hagerstown Washington 21327 Old Forge Rd. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 X M 2 □ F 201-16-6156 84 Director Aug. 30, 1925 Pennsylvania Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinor must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Washington Hagerstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 U.S.A. 21327 Old Forge Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Arn 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1943-1947 filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. \$ Specify: White 3 X Widowed 4 □ Divorced Army Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Mechanic Motor / Auto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be Raplh I. Gift Mary C. Law ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21327 Old Forge Rd. Hagerstown, Maryland 21742 permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra D. Jean Strite (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) September Burn's Hill Cemetery Waynesboro, PA 25, 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 10 Rea 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Stage IV Squamous Cell Cancer of the Tongue **Physician** veal resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 ☐ Other (specify) □Yes 2□No detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ⋧ Obstructive hung 1 Ves 2 No 3 Probably 4 Unknown Completed has been Pulmonary Embelism 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 1 □Yes 2 DIN or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation death. ieral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) September 23, 2009 29b. Signature and title of certifier 29c. License number Kuttney-Sand, no D47451

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) as hing ton County, 747 Northern Avend Cynthia Kuther-Sands we Hospics of Washington Wagerstown, Maryland 21742

747 Northern Avenue,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 21, 7:10 PM 2009 CHARLES Murry GALLAHAN 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 456-56-7018 77 Virginia May 22, Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Purcellville 1 ☐ Yes 2X No Virginia Loudoun 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20132 United States 37778 Legard Farm Road 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces' Armed Forces? 1 ★Yes 2 No 1950If Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4or 5+) Mail Carrier Postal Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Pearson Raymond Gallahan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 37778 Legard Farm Road, Purcellville, Virginia 20132 Janice C. Gallahan / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition September 25, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hillsboro, Virginia Hillsboro Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 21. Signature of Funeral 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one captage on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): yes, outcome of pregnancy 23d Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown TYPASP

Physician /Medical Examiner

Department of H Important: If ite any injury or ot

Physician

/Medical

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**Funeral** 

Director

28a-f show

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ed other than "natural", or items 23a or 28a-f show event, the Medical Evant are must be multified at

Pages 1 and 2 should be filed within 72 hours after death with trent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or?

Baltimore, Maryland 21215-0036

burial-transit and signed by the a has been

attending physician for use as the buria this certificate

Physician/Medical Be

After 24 hours after death. completely filled in by the

To the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records,

P.O. Box 68760.

within 2 To the I

State

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner IF FEMALE: 23b. Was decedent pregnant in the past 12 months? □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗆 M6 1 Inpatient 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

160417

9-22-09

Dr. Frederick MB 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

shah Lomas

31. Date filed (Month, Day, Year) 29 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year ehtember 200 Kathleen Celeste Galiano 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner imore If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 08–20–1944 9. Birthplace (State or Foreign Country) Maryland Social Security Number If Under 1 Year 7. Age (II Months Hours Days 1 □ M 2 📆 🛣 65 217-40-6053 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State XXYes 2 □ No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 86 Whips Lane 21236 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2**XX**No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 □Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2\No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Private Sector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John O'Connor Marie DeLuca 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael J. Galiano-Son 11946 Galaxy Lane, Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Atlantic Crematory 09-11-2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, n each line. Immediate Cause (Final alo disease or condition resulting in death) Due to (or a a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available Medical Certification: To Be

/Medical Examiner

Physician

**Physician** 

**Funeral** 

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modified at

Pages 1 and 2 should be f ment of Health and Mental

Baltimore,

P.O. Box 68760,

Division of Vital Records,

other

Department of Important: If it any injury or of once.

/Medical

death certificate be executed burial-tran physician the. use as t attending for detached or Attending Physician: The law requires that the by signed b page 2 certificate has this

After th funeral death, the 1 within 24 hours after deat To the Funeral Director: filled in by

	-2.5 - 7 - 7 - 7				autopsy performed? 1 □ Yes 2 ANo	death?  1 □Yes 2 ☒No		
25. Was case referred to medical		26. Flace of Death (Check only one)						
examiner? 1 ☐ Yes 2 💢 I	No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 2 ☐ Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of 2 Injury M	8c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury oc	ccurred		
3 ☐ Suicide 4 ☐ Homicide	6		ome, farm, street, factory	office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one)		hysician: To the best of my known iminer: On the basis of examinating and manner stated.						

State

9000 el

29c. License number

29d. Date signed (Month. Day, Year)

Ln 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Franklin

31. Date filed (Month, Day, Year) SEP 10

29b. Signature and title of certifier

32. Registrar's Signature

Registrar

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Elizabeth Green 9/14/2009 11:40 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care Chevy Chase Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 075-07-5193 1 □ M 2 🖫 F 90 Director 11/30/1918 NY Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Modical Examiner must be notified at DC N/A Washington Director Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Street and Number 2922 Fessenden ST NW 20008 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc and 2 should be filed within 72 hours after □Yes 1 Never Married 2 Married 2 No 1 ☐Yes 2 No If Yes. Give Specify: Specify: WHITE 2 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Private Elementary/Secondary (0-12) College (1-4or 5+) Domestic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick Whalen Margaret Gilligan ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health an Important; if item 27 is m any injury or other. Kim Green / Son 2922 Fessenden ST NW Washington, DC 20008 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 9/15/2009 Riverdale, MD Riverdale Park 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Bianchi 814 Upshur St NW Washington, DC 20011 23a. Part 1. Enter the dise of or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) Stroke /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of the purple that initiated events Examiner Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Ye ar 4 Pregnant at time of death 5 Other (specify) ☐Yes 2XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate **2**XXNo 1∐Yes 2. No 1 □Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death.

Director: After 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 TSuicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, 24 hours a Hospital

Saltimore, Maryland 21215-0036

P.O. Box 68760.

State Registrar

**Wedical** 

(Check only one)

29b. Signature and title of certifier

Dr. Sunitha Bhogavilli 9801 Georgia Ave #117 Silver Spring, MD 20907 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D0054566

29d. Date signed (Month, Day, Year)

9/14/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 1905 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita Talbo Memorial Easton 1 Year If Under 24 Hrs. Security Numbe If Under 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral ™**M 2 □ F Director Usual Residence of Decedent 10b. County or 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 🗆 No -lorida 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Peoples Department of Health Important: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔲 Burial 2 🗆 Cremation 3 🔭 Removed from State 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of theral Service Lice 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Immeriate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 🗌 No signed by the g Unknown g Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 1 No N 1 Tes Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) exarciner? 1 Yes 2 □ No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) **Natural** 5 Pending Accident 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or in only one 3 Certifying Nurse Practioner: To the best of my e death occurred at the time, date and place, and due to the cause(s) and manner as stated. 18

State Registrar

Gadsden

or Attending Physician: To the Hospital or Autorom, within 24 hours after death.

To the Funeral Director: Af

State Registrar

31. Date filed (Month, Day, Year)

Lianna Ayotte, M.D.

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

106 Bow St. Elkton, MD. 21921 32. Asgistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DOD68591

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 11 2009 **Physician** 4:55 p.™ Bessie Elizabeth Harrah /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cambridge
If Under 1 Year If Under 24 Hrs. Mallard Bay Care Center Dorchester 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Director <u>215-20-1414</u> 83 May 23, 1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director MD Dorchester 1 XYes 2 □ No Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Glenburn Avenue 21613 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: à Specify: white 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other transmit. Elementary/Secondary (0-12) College (1-4or 5+) licensed practical nurse hospital unknown Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Burton Jackson Sr. Agnes Hubbard 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Gehring daughter 6810 Unit 2 Eldorado Rd., Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 9/15/09 Cambridge, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Thomas Funeral Home P.A. K 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine the Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician Box 68760 Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 ■ No 24b. Were autopsy findings available prior to completion of cause of death? has 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 Pending investigation To the nuc.
within 24 hours after uc.
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 31. Date filed (Month Pay, Year) State Registrar

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Thomas Α. Haviland 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HICIMICO FENINSULA 501156419 REGIONAL MPSICAL If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year Age (In yrs. last birthday)
66 Yrs. 8. Date of Birth (Month, Day, **Funeral** 218–40<del>–</del>7948 Days 12/07/1942 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examination at any injury or other traumatic event, the Marical Examination at any injury or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2X No Directo Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 26140 High Banks Drive 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Myes 2 □ No If Yes, Give AirForce Year or Date AirForce 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: white ģ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trucking truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Little James Haviland ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
26140 High Banks Dr., Salisbury, MD 21801 19a. Informant's Name/Relationship (Type. Print) Nancy Haviland/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 9/14/09 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Phonical Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOUARDIAL 15 CHENIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CARDIOGENIE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed ASUVA Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 2 N ER/Outpatient 3 □ DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending investigation or safter dea... eral Director; A^r v filled in by the 1 Yes 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

7 mt

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Truman E. Hendrickson Jr. 12:40 AM September 15 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 100 West Branch Circle North East Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7/e 1939 7 3 Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 212-38-0549 Days Months 70 1 X M 2 □ F February Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XXNo Maryland Cecil North East 10e. Street and Number 10g. Citizen of What Country? 21901 United States 100 West Branch Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: 1958–61 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking/Construction Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) Mary Childress 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 West Branch Circle, North East, Maryland 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 2009 Newark, Delaware 16 Mayerdale Crematory 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 Approximate Interval Between Onset and Death OBSTRUCTIVE PULLOWARY DISEASE CHRONIC YEAKS Due to (or as a consequence of) Due to forces a consequence offi Due to (or as a consequence of):

**Physician** /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

**Funeral** 

Director

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show

Pages 1 and 2 should nent of Health and Mer

of Health a

permit. Pages Department of Important: If it any injury or or

Baltimore, Maryland 21215-0036

other traumatic event, the Medical Exeminer must be notified at

attending physician and the been signed by After this

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a

Division of Vital Records, P.O. Box 68760,

4+1VA State



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Janice Rayetta Irving 1555 2005 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Days Feb., Dy1Year) 1927 Mary Yand 216-22-8288 82 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗆 Yes 2 🄀 No Washington Boonsboro Maryland 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20728 El Rancho Road 21713 U.S.A. items 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. 1 Never Married 2 Married "natural", or þ Maryland 21215-0036 1 Yes 2 X No Specify 3 X Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 华 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kieffer Armatha Α. Ford permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic vonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Irving, Sr. / Son Boonsboro, Maryland 6006 Rohrersville Road 21713 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Beaver Creek Cemetery 09/18/2009 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsbor 21713 Boonsboro, 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death CEREBRO VASLULAR Physician/ ALCIDBUT disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DISENSE OBSTAW GRUE LUNG DNIC MONTTHS Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed DISORDER UR that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ as been signal Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performe page 2 1 ANO 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) မ 1 Tyes 2 No 1 Denpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu death. 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner stated

State

DADIR GHAZALA 1190

mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month SEP) 16

29b. Signature and title of certifie

Registrar

29c. License number

HAGUSTOWN MD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Vear Month 930 Lloyd Bernard M 13 200 NEEMber 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Lanham Doctor's Community Hospital 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 24, 5. Social Security Number 7. Age (In yrs. last birthday) Min. 1 X M 2 □ F Months Days Hours 1934 220-28-5024 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1X Yes 2 No Prince George's Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20707 911 7th Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 X No Specify. Specify: Black 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Thoroughbred Racing Horseman 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helena Louise Thomas Bernard Nathaniel Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 7th Street Laurel, MD 20707 Shirley Ann Chittams/sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation Final Journey Crematory 09/16/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEVERE disease or condition resulting in death) Due to (or as a consequence of): TRONIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Examiner The law requires that the death certificate be execute burial Box 68760. attending physician the as Sel for ped o the ed by t σ. Division of Vital Records, sign be

**Physician** 

/Medical

Examiner

10a, State

Director

Funeral

Completed by

Be

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Examine

Physician/Medical

Be Completed by

Certification: To

Medical

29b. Signature and title of certifier

Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

Department of Important: If it any Injury or o

**Physician** 

/Medical

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 212 5-0036

page 2 s certificate this nours after death.

neral Director: After this

filled in by the funeral di

			1 ☐ ¥es 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
			24a. Was an autopsy findings available prior to completion of cause of death?  1 \( \superscript{Yes} \) 2 \( \superscript{MNo} \) 1 \( \superscript{Yes} \) 2 \( \superscript{NNo} \)
25. Was case referred to medical	_	26. Place of Death (	Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 4 Impatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury	c. Injury at Work? 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, obuilding, etc. (Specify)	office 28	f. Location (Street and Number or Rural Route Number, City or Town, State)
	ysician: To the best of my knowledge, death occurred a niner: On the basis of examination and/or investigation, i		

30

or Attending Physician:

Hospital thin 24 hours a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parkary, Suite 101A, Greenbelt, MD. 20770 Cecil D. George 7500 Hanover gistrar's Signature

29c. License number

MOD 58182

State Registrar

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Voar **Physician** SEPT. 10:04 PM **JEWELLS** 12 2009 RUSSELL W. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death **Examiner** 11954 EAST YARDARM DRIVE WORCESTER BERLIN If Under 24 Hrs. (State or Foreign 8. Date of Birth (Month, Day, Year) Birthplace Country) 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours 1 KM 2 D F 9/8/1926 Director 209-14-7844 83 MT Usual Residence of Decedent 10d. Inside City Limits t be notified at 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director WORCESTER MD BERLIN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with r than "natural", or items 23a UNITED STATES 11930 WEST YARDARM DRIVE 21811 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1944-46 1 ☐ Yes 2X No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) PHARMACEUTICAL Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE SUPERVISOR 11 MANUFACTURING is marked other 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be innent of Health and Mental RUSSELL W. JEWELLS VIOLIA T. WITTIG ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any injury or other trau 11954 EAST YARDARM DR BERLIN, DAVID R. JEWELLS/SON MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DELAWARE VETERANS MEMORIAL CEMETERY 9/18/2009 BEAR, DE 22. Name and Address of Facility SPICER-MULLIKIN FH 10 1000 N. DUPONT PKY NEW CASTLE, DE 19720 Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consquence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) 68760 Physician/Medical attending p Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown signed the bed better Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 □No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

der

32. Registrar's Signature

DHMH 17 Rev 1/2001

314 Franklin

29c. License number

29d. Date signed (Month. Day. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Janet Lorraine KIPE 8:20 PM 2009 September Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Washington County Hospital Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral (Month, Day, ) 1 M 2 X F 85 217-12-2182 Maryland Director 1923 Usual Residence of Decedent 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Maryland Washington Hagerstown 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 Richmond Street, Apt. 6 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 🛂 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married . Page 1 and 2 should be filed within 72 hours after ament of Heatht and Mental Hygiene. Fart If them 27 is marked other than "natural", or tury or other traumatic event, the Medical Examin tury or other traumatic event, the Medical Examin 1 Yes If Yes, Give 1 ☐ Yes 2 X No Specify: white Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) hospital nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harvey Mason Troupe Florence Leatherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward R. Kipe - son 20010 Gilbert Hills Dr., Hagerstown, Md. 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth Date cemetery, crematory or other place) 1 Neurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lutheran Cemetery 9/19/09 Leitersburg, Maryland 21. Signature of Europe Service Lie 22. Name and Address of Facility MINNICH FUNERAL HOME Ε. Wilson Blvd., Hagerstown, Md. 21740 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. terval Between Onset and Death Immediate Cause (Final Physician 0 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical IF FEMALE Jurcon e of pregnancy ive Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death 2 No 1 ☐ Yes ∠ ⊭ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 2 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) 5 Pending injury Natural 1 Yes 2 No 2 Accident Investigation Suicide Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and czompieled filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760

Maryland 21215-0036

Baltimore.

L'Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

HALLAB 31. Date filed (Month, Day, Year) State



Registrar

1

Medical

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State o	f Marylan		rtment d tificate d			ental Hy	/gien Reg. N	10	100	01000
		Registrar  1. Decedent's Name (First, Middle	, Last)			- Invocto C	J. Douil		2. Date of De	eath	এল ভ		3. Time of Death
Physici Medi		William C. Kren	ann						Month Sept.		ay 8 2	Year 2009	10:13Å
Exami		4a. Facility Name (if not institution, Regency Assist	•	ber)		4b. City, Tow Gamb 1	n, or Location	on of Death				of Death Arun	de1
Funeral Director		5. Social Security Number 215-20-3093	6. Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs. la	as <i>t birthday)</i> Yrs.	If Under 1 Y Months D	ear If Und ays Hour		8. Date of Bi (Month, Di 09-24-		5	9. Birthp Count Ohio	place (State or Foreign try)
ld now at		Usual Residence of Decedent  10a. State 10b. County		10c City	y, Town or Loc	ation						1	0d. Inside City Limits
arylar ta-fsh ified	Director	Maryland			ltimor								1 XXes 2 □ No
/ith the M 23a or 28 st be not		10e. Street and Number 218 Mallow Hil	1 Road			10f. Zip Co					Citizen of V	What Cour	itry?
<b>Baltimore, IMaryiand Z1Z13-0036</b> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1  Never Married 2  Mari	ied Armed Fo 11 Yes If Yes, Giv	2 □ No e	lf 1		Cuban, Mexi	Origin? (Spec can, Puerto R		~		e - Americ ck, White, (	
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ytand Id be filed Mental Hy larked oth	To Be	17. Father's Name (First, Middle, L Charles Kreman	•					other's Name arah M	, ,		n Surname	e)	
Mary 2 shouk th and h 27 is me trauma		19a. Informant's Name/Relations	nip (Type, Print)		1			nber or Rural					Code)
e, R and 2 Health em 27		Timothy Krema 20a. Method of Disposition	nn -Son	20h F	262 Dace of Dispos			ourt,	Arnold	$\overline{}$		)12 - City or To	nwn State
TOF age 1 ent of nt: If it		XX Burial 2 Cremation 4 Donation 5 Other (S		State St.	emetery, crem George rch Cei	atory or other	r _{place)} copa1			1		-	Maryland
<b>Baltimore,</b> permit. Page 1 and Department of Hes Important: If item any injury or othe		21. Signature of Funeral Service L		ICnu	22	Name and A	ddress of Fa	is Robe	rt E.	Eva	ns Fu	ınera	1 Home
ate be executed  The burial-transit  The burial-transit	Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	a. Due to	cor as a consequence of as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the con	uence of):	r the mode of	dying, such	as cardiac or	respiratory a	rrest,		5	Approximate Interval Between Onset and Death
DIVISION OF VITAL RECORDS, P.O. BOX 68/00  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	1 Live	come of pregna Birth 2  Feta nant at time of d	aldeath 3 🗌	Ectopic preg   Other (speci						ate of deliver	ery Day Year
S, F.	ğ	Part II. Other significant condition	ns contributing to d	eath but not res	ulting in the u	nderlying cau	se given in P	art I.					ne cause of death?
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VITAI  ysician: s certific director,	To Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatien		Other:	Death (Check		idence	6 Africa	er (Specify	455 coper france
n or ding Phy th. After thi funeral		27. Manne Death  1 Natural 5 Pendir 2 Accident Investi-	28a. Date (Mon	-	28b. Time of injury	28c.	Injury at work?	2	8d. Describe				
JIVISION al or Attendii s after death. I Director: A	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At hong, etc. (Specify				-	28f. Location City or To			er or Rural	Route Number,
he Hospit in 24 hour he Funera	Medical	(Check 2 Medical E	Physician: To the base examiner: On the base Nurse Practions	s of examination	n and/or invest	igation, in my	opinion, deat	n occurred at t	the time, date	and place	ce, and du	e to the ca	use(s) and manner stated.
To t with To th		29b. Signature and title of certifier	- K	but	5	K	nse number	994		29d. D	ate signe	d (Morith,	9
Hlett		30. Name and address of person	on My	se of death (Item	14/1	rint Mac	dism	Park	CD/	rev (	6	ten !	wrnil ud 20
Su Regist	ate rar	31. Dat filed (Month, Day, Year)  SEP 1 (	2009	egistrar's Signa	A. A	arks					nii		67

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#'s20a.b.&c.PerFHPGC9-22-09Cf 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Berthell Kelly 22:36 P 2009 /Medical September 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Dorchester County 1□M 2⊠F Months Days Hours Min. 257-34-9359 Yrs. 85 03/24/1924 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it a Madical Examitant must be notified at DC 1X Yes 2 □ No Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1343 Emerald Street NE 20002 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Black δ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Green Minnie McCants ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8401 Owens Way Cassandra Harrison/Daughter Brandywine, Md. 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September TABurial 2 ☐ Cremation 3 ☐ Removal from State Clinton 4 □ Donation 5 ▼Other (Specify) Entombed 19, 2009 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sin ature of Funeral Service License 4001 Benning Rd. NE Washington, DC 20019 23a. Parf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Immediate Cruse (Final Physician disease or condition resulting in death) cardionyo but /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine nding physician and use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atter for u 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a d be detached for 1 ☐Yes 2 XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ by vascul 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an 1 ☐ Yes 2 No the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Fafter death. After Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in thin 24 hours a Hospital † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sures ater, MD Sunzitis Rel Clinton, mp 20731 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Stete Registrar	State of	Marylan		rtmen tificate			and M		giene Neg. No. 0 (	Mark Company	31222
П	Dhuaiai		1. Decedent's Name (First, Middle, L.								<ol><li>Date of Dea Month</li></ol>	Day	Year	3. Time of Death
	Physici /Medio		WILLIAM	A ·	KB	CAN					09-	10-20		02:30 A·M
3	Examir		4a. Facility Name (If not institution, gi		er)		4b. City,		Location o			4c. Count		
			HOLLY CR	NTAR					HIS	_	,	1		mico
	Funeral		Social Security Number 6.	Sex 7. 1X M 2 ☐ F	Age (In yrs.	last birthday)	If Under Months	1 Year Days	Hours	Min.	8. Date of Birtl (Month, Day 08/26/1	Year)	Col	place (State or Foreign untry)
	Director		219-70-8490	A.1M 201	70	Yrs.					08/26/1	.939	Mary	vland
	pu s		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	show	5												1 □ Yes 2 XNo
	28a-f	ect	Maryland Wicomic		Del	mar	10f. Zip	Codo			1	10g. Citizen of	What Co.	into/?
	T O T	Funeral Director					218					USA	77.1at 00.	, .
	s 23	ra	8835 Woodcreek P	12. Was Decede	nt Ever in III	.S. 13. \			enanic Ori	nin? /Sne	cify Yes or No-		ice - Amer	ican Indian,
	ltem Item	ů	11. Marital Status 1   Mover Married 2 Married	Amed Force	s?	.3.	f Yes, spec	ify Cuba	n, Mexican	, Puerto F	cify Yes or No- Rican, etc.)		ack, White	
36	rs aff	Ş.	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		1 □ Yes 2	No No	Specify:			Speci	ify: Wh	ite
215-0036	72 hours after death with the Maryland naturel', or Hems 23a or 28a-f show ileal Evarili wr mast be molified at	Completed by	15. Decedent's B			16a. Dece	dent's Usua	I Occupa	ation			16b. Kind of 8		
15	in 72 an " c	bet	(Specify only highest g	rade completed)	5 . \	(Give	kind of wor DO NOT us	rk done d e retired	luring mosi )	t of workir	ng			
212	i within iene.	E	Elementary/Secondary (0-12)	College (1-4d	or 5+)	n/a						n/a		
b	othe othe	BeC	17. Father's Name (First, Middle, Las	st)					18. Mothe	r's Name	(First, Middle,	Maiden Suma	me)	
<u>a</u>	id be lenta ked lc ev	To B	William Kegan Sr	•					Lou	ise H	Kidd			
Maryland	12 should be filed within "h and Mental Hygiene." I's marked other then "treumetic event, the Med		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	r or Rura	l Route Numbe	r, City or Town	n, State, Z	ip Code)
Ž	nd 2 alth a 27 Is		Martha Graham/sis	ter		308 Ka	y Ave	2., 5	Sails	oury,	Maryla	and 218	301	
ā,	Hear Hear Item othe		20a. Method of Disposition		20b. F	Place of Dispo					ate	20c. Location		Town, State
٤	age ento ento y or		1 ☐ Burial 2 ☑ Cremation 3 ☐ Other (Spec		ile	Lisbury				09/14	1/2009	Salish	urv,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Interportent: If item 27 Is marked other then "naturel, or items 23a or 28a-f show languid to other treumetic event, it a Mudical Ever it instrugist by rudified at once.	1 9	21. Signature of Funeral Service Lio		Das				-					
Ba	permi Depa Impo eny it		1 Hould ST A	DRIMON.	CECK	그 방	ollowa Ol Sno	y Fu	inera 11 R	Hor Hor	ne P.A.	rv. Mar	-vlan	d 21804
	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Due to (or	RD/ as a conseq 1/2/4	omy quence of): Tio~					r respiratory ar		SNT	Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq									
P.O. Box (	the death certitically the attending physiched for use as the	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknown	t at time of c	ıldeath 3□	]Ectopic pr ] Other (sp						ate of deli fonth	very Day Year
	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions	contributing to deat	h but not res	sulting in the u	nderlying c	ause give	en in Part I		23e. Did to			the cause of death?  bbably 4 □Unknown
Records,	The lay ate has page 2	Completed									24a. Was autop perfor 1 Tes	an 24b sy rmed2 2 No	. Were au prior to d death? 1 ☐ Yes	topsy findings available completion of cause of
/ita	ding Physicien: Th h. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?								(Check only o			
<del>_</del>	hysic his c	၉	1 ☐ Yes 24 █ No			ER/Outpatier					ne 5□Resid			city) TCHROD
_	ng P Mer t Inera	ü.	27. Manner of leath  S☐ Pending	28a. Date of I (Month,	njury Da <i>y Ye</i> ar)	28b. Time of Injury		8c. Injury Work			28d. Describe h	low injuly occi	urred	
Division of Vital	Attending r death. sctor: After by the fune	Certification;	2 ☐ Accident investigati	ha			М		Yes 2□					
ï≅	ter direct	ŧ	/ 3 Suicide 6 Could not 4 Homicide determine	286. Place of	Injury - At h etc. (Specia	ome, farm, str fy)	eet, factory	, office		1	28f. Location (S City or Tov		nber or Ru	ral Route Number,
0	ital c rrs af ral D led ir	ပိ												
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	edicai	29a. Certifier Certifying F (Check only one) Medical Exe	Physicien: To the be eminer: On the basi and manner	s of examina	ation and/or in	vestigation	in my o	oinion, dea	th occurr	ed at the time,	date and place	, and due	to the cause(s)
	onthin rompl	Me	29b. Signature and title of certifier				290	. License	number			29d. Date sign	ned (Monti	h, Dey, Year)
)	1		1	~				Do	205	241	10	91	111/	09
	2 m		30. Name and address of person who	o completed cause of	of death (Iter	n 23a) (Type	Print)			147	1	. /		r
	0			y 926	SNOW	WHILL	A	0.	SA	LijA	uner	MID	2	1204
	Sta	ite	31. Date filed (Month, Day, Year) SEP 15	32. neg	istrar's Signa	atur	a. N. J	/		-5 0	-	1000		
	Regist		SEP 15 2	2009	en .	13. AP	and				uney			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 14 Physician/ 614 2009 Ralph Lee Long Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Washington County Hagerstown Washington County Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Yea ine 25.1 Mary Land 1 XM 2 □ F Months Days Hours Director 217-28-5897 Yrs. June Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the M. dical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🌠 Yes 2 □ No Maryland Washington county Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21740 U.S.A. 1175 Professional Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 ▼ Yes 2 □ No If Yes, Give Black White etc 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Newspaper Asst. Circulation Manager permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, ? Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Frances Grace Turner Long George Clifford Long, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21613 Mt. Lena Rd. Boonsboro, MD 21713 Kathy Henneberger-daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 9-16-2009 Smithsburg, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exam that the death certificate be executed and as the burial-tran resulting in death) Last physician Physician/Medical Box 68760 attending IF FEMALE: for use 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year ed by the a detached f 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed be should be deta þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 the Hospital or Attending Physician: The Ihin 24 hours after death.

the Funeral Director: After this certificate In repleted filled in by the funeral director, page 1 🗌 Yes 2 1 No 26. Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manne eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 2 To the P 29d. Date signed (Month, Day, Year) 4 OPAL COURT, HACTERSTOWN, MD 21740 nd address of person who completed cause of death (Item 23a) Type, Print)

PHY L- WH-BCB M D U SH 5+ 31. Date filed (Month, Day, Year) SEP 16 State Registrar

DHMH 17 Rev 7/2009

		1 - For State Registrar	State of Mar	•		of Health and of Death		giene Reg. No.	9 31224
Physi /Med		Decedent's Name (First, Middle, La     George Wa		ampkin		· ·	2. Date of Dea Month	Day Ye	3. Time of Death
Exam	iner	4a. Facility Name (If not institution, given Prince Georges Ed. S. Social Security Number 6. S. 416–60–3301	lospital Cer	nter In yrs. last birthday) 4 Yrs.	<b>Ch</b> If Under 1	own, or Location of Dea everly Year If Under 24 Hrs Days Hours Min	8. Date of Birti	h 9.	Georges Birthplace (State or Foreign Country) Alabama
Directo		Usual Residence of Decedent  10a. State  10b. County		0c. City, Town or Lo	cation		panuary	2,1743	10d. Inside City Limits
e Ma 8a-f s	Director		Georges	Lando					1X Yes 2 No
with the	Dir	10e. Street and Number 3523 Brightsea	t Road		10f. Zip (	0785		10g. Citizen of Wha United S	
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evaninar must be notified at	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Evr Armed Forces? 1		Was Decede f Yes, specif	ent of Hispanic Origin? (. fy Cuban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No- rto Rican, etc.)	14. Race - , Black, V Specify:	American Indian, White, etc. Black
215-( nin 72 h ni "natu	Completed by	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	1 (Give	dent's Usual kind of work DO NOT use	Occupation done during most of wo retired)	prking	16b. Kind of Busin	ess/Industry
2121 2121 3d within /giene. er than"	l E	12th grade	College (1-401 5+)	Ware	house	Technician		Giant Fo	oods
Maryland 212- nd 2 should be filed within the and Mental Hygiene. 27 is marked other than traumatic event, the Mary	To Be	17. Father's Name (First, Middle, Last, Rozelle Lampk					me (First, Middle, Le Mae	Maiden Surname) Jordan	
Maryla d 2 should I th and Men T is marke		19a. Informant's Name/Relationship ( Hazel Garey Lamp)	Type Print)	Y I	-	Street and Number or F			
ting t. Pa rtmer rtant:	onice:	Tammi Richardson  20a. Method of Disposition  1 Burial 2 A Cremation 3 5 Other (Special Service) 21. Signature of Funeral Service 1 c	Removal from State	20b. Place of Dispo cemetery, cren Chesapeak	sition (Name natory or oth ce Cre Name and	e of ner place) Sept matory, Inc Address of Facility R.		20c. Location - Cit  Beltsvill  on Compan	
figure be executed Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 physician and Figure 19 p	ì	23a. Part 1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acute Due to (or as a of	Renal consequence of):	Foils	sease	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death
death cert death cert e attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1  Live birth 2	☐ Fetal death 3 ☐	∃Ectopic pro ∃Other (spe			23d. Date o Month	
ecords, P.O. law requires that the das been signed by the 2 should be detached	þ	Part II. Other significant conditions of	contributing to death but	not resulting in the u	nderlying ca	use given in Part I.			ute to the cause of death?  ☐ Probably 4 ሺ Unknown
0	Completed						24a. Was autop perfor 1 □ Yes	osy prio rmed? dea	re autopsy findings available or to completion of cause of ath? ]Yes 2 □ No
VIta sician certifi rector,	Be	25. Was case referred to medical examiner?	Hospital:			Other:	eath (Check only o		
vision of Vital Ri Attending Physician: The r death. ector: After this certificate h by the funeral director, page	ion: To	1  Yes 2  No  27. Manner of Death 1  Natural 5  Pending	28a. Date of Injury (Month, Day,	2 ER/Outpatier  28b. Time o Injury		A		dence 6 Other	(Specify)
를 함께 를	Certification: To	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 280 Place of Injury	r - At home, farm, str (Specify)			28f. Location (S City or Tox		or Rural Route Number,
the Hospital hin 24 hours a the Funeral I	Medical (	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	hysician: To the best of miner: On the basis of each manner state	xamination and/or in	h occurred a vestigation,	at the time, date and pla in my opinion, death oc	ce, and due to the curred at the time,	cause(s) and manr date and place, and	ner as stated. d due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier				License number		29d. Date signed (I	
<u>a</u>		30. Name and address of person who	Block cause of dea	th (Item 23a) /Time		1004718	3	September	r 14, 2009
23	tate	Karen Brooks, M 31. Date filed (Month, Day, Year)	.D.; 3001 H	ospital D	rive;	Cheverly, h	Maryland	20785	
Regis		CED 1 7 2009	Munas &	s Signature					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month 10:15 AM Linda Glenell Lankford 2 2009 Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 50/156410 HICOMICA ININSULA REGIONAL DOICAL If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 M M F Months Hours 50 Director Dec. 31. 1958 Delaware 216-70-2140 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiens in International Content of Health and Mental Hygiens I hattured to the Talmarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment must be notified at once. 1 ☐Yes 2 No Funeral Director Vienna Maryland Dorchester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4822 Ocean Gateway 21869 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 → Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: <u>م</u> 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Duty Service CNA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Glen White Helen Marie Williams ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronnie_Nutter/son 4822_Ocean Gateway, Vienna, Maryland 21869 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Wesley U.M. Ch Cem. 9/18/2009 4 ☐ Donation 5 ☐ Other (Specify) Vienna, Maryland 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD Signature of Funeral Service Licens 21801 JOLLEY MEMORIAL CHAPEL Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** OW TW disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation s after death. 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month. Day, Year) 29b. Signature and

Box 68760.

P.0.

Division of Vital Records,

State Registrar

Sausanny

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M110

32. Registra/s Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Sep 21, 2009 Physician 1310 Mazuran Elizabeth Marguerite /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Frostburg Village Nursing Home Frostburg Date of Birth (Month, Day, Year Dec 14, 1 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 □ F MD 219-03-8580 Director Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be notified at 1 ☐Yes 2 ☐ No MD Allegany Frostburg **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21532 USA One Kaylor Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ No Baltimore, Maryland 21215-0036 Specify: Specify: 2 white 3 XWidowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Memorial Hospital Nurse's Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Huff Steinbaugh Champ Steinbaugh ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 85650 2999 Glenview Drive Sierra Vista ΑZ Mary Kowell daughtei 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Bemoval from State 9/26/200 Sunset Memorial Park MD Cumberland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility all Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Rart1. Enter/the diseas...or complice from sheat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure/ List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DRONARY /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 No signed by the a d be detached for P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably STRUCTIVE LUNG page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27, Manner of Death 28c. Injury at / 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 02690 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARJIT SIDHU, MD 925 BISHOPWALSHRD, CUMBERUND, MD ZISOZ

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 09 elen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** JUSH Hagerstown nder Tyear | If Under Washington County Hospital Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) Hours 1 □ M 2 🛛 F Months Virginia 72 West June 16 1937 **Director** 214-34-9754 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Int. Medical Examiner must be rediffed at 1XYes 2 □ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21740 63 E. Antietam Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dress Factory 12 0 Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Virginia Campbell William Charles Mundey, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 117 Greenwood Drive, Hagerstown, Maryland 21740 Paul Mundey - Brother Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/17/09 Hagerstown, Maryland Hagerstown Crematory 21. Signatur - Foreral Service License 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 17 theroso 000 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disc to for as a consequence off Examiner death certificate be executed and physician are the burial-to Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the attending phase as the IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 5 ☐ Other (specify) 1∐Yes 2NNo sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown The law requires that the 23e, Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physiclan; The law within 24 hours after death. ▼To the Funeral Director: After this certificate has l autopsy 1 ☐Yes 2 ☐ No 2 No 1 🗆 Yes Hospital or Attending Physician; 26. Place of Death (Check only one) 25. Was case referred to medical Be aminer' Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 😾 DOA Certification: To completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Mosth State Registrar

29b. Signature and title of certifier

OD KS MD Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

120011266

Ner Thorn Ar

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** nne 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Dorches Birthplace (State or Foreign Country) Social Security Number last birthday) Date of Birth (Month, Day, 7. Age (In yrs **Funeral** Year Days Hours 139-26-9 1 M 2 □ F Months Director -eb.1 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show death with the Marylar the Medical Exacilmer coast be notified at 1 Yes 2 □ No Funeral Director Dorchester 10g. Citizen of What Country? 10e. Street and Number amper 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. þ Specify: Black 3 Widowed 4 Divorced "naturai" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene, Important: If item 27 is marked other than any injury or other traumatic event, the Maone. College (1-4or 5+) Elementary/Secondary (0-12) Salvage Recycler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnson EMMa GOUID ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cambridge MD: 21613 De SSie MCK: nney TillMan 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Bethel Cemetery Cambridge 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility HENRY FUNERAL HOME, P. A. 510 Washington St. Cambri 21. Signature of Funeral Service Licensee MD.21613 Approximate Interval Between Onset and Death 23a. Part T. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnency
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To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar Male 32. Registrar's Signature

31. Date filed (Month, Day, Year) SEP 16

Michinel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Fund Direct			5. Social Security Number 040-26-3156	6. Sex 1 □ M 2 □ F	7. Age (In yrs. <b>86</b>	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da June 12		9. Birthplace (State or Foreign Country) Ukraine
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State Registrar

DHMH 17 Rev 1/2001

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			for State Registrar	State of I	Marylan	-	artmen <i>rtificat</i>			and N	lental Hyg	jiene leg. No.	000	312	30
	Physic	an	1. Decedent's Name (First, Middle, i	,							Date of Dea     Month	th Day	Year	3. Time of E	Death
	/Medi		Clyde Dale Nunle	<del>-</del>							09-08-			0730	М
	Exami	ner	4a. Facility Name (If not institution, g		,				Location of	of Death			ounty of Death		
4-12			Anne Arundel Med  5. Social Security Number 6		er Age (In yrs. I	ast hirthday)	If Under	napo 1 Year	L1S If Under	24 Hrs.	8 Date of Birth		ne Arun	nplace (State or	Foreign
h	Funeral Director		447-40-0459	1 <b>XX</b> M 2□F	70	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day 10-06-1	938	Cou	intry) ihoma	roragn
	Pu »		Usual Residence of Decedent  10a. State 10b. County		100 Cit	, Town or Lo	antion							10d. Inside City	Limito
	the Marylan 28a-f show	tor	Maryland Anne A	rundel		ofton	cation							1 XXXes 2	
	or 28a	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citize	en of What Cou	untry?	
	23a c	a	1605 Earlham Av	enue			2	1114				1	U.S.A.		
	r dea	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S	3. 13.	Was Deced	ent of H	ispanic Ori n, Mexicar	igin? (Sp	ecify Yes or No- Rican, etc.)	14	I. Race - Amer Black, White		
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examirar must be notified at	þ	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced		□ No		1 □Yes 2		Specify:		,			hite	
5-0	72 hou	Completed	15. Decedent's (Specify only highest of	Education	- 1	16a. Dece	dent's Usua kind of wor	l Occup	ation	t of work	ina	16b. Kind	d of Business/I	ndustry	
121	ithin ne.	g E	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	DO NOT us	e retirea	)	. 07 11071	,,,9	U.S	.GOVERN	MENT DO	D
	iled w Hygie ther t		17. Father's Name (First, Middle, La	8+ st)		Mat	hmati	cian		r's Namı	e (First, Middle, i	Maiden Si	urname)		
an	d be fental ced o	o Be	Cecil Clyde Nun								ıline Co		•		
Maryland	shoul nd Mi marl imati	은	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street			al Route Numbe			ip Code)	
	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		Irene M. Nunley	_ Wife							Crofton,			•	
Ore	of He		20a. Method of Disposition		I ~	ace of Dispo	sition (Nan	ne of	- 1				ation - City or T		
Ē	Page ment ant: I		MXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		te Calv	ary C		•		•	4/2009 T		-		
Baltimore,	permit. Pa Departmer Important: any injury		21. Signature of Funeral Service Lic	ensee		- 1				•	ert E.				!
	<u>₽</u> □ = # 9		(Ichn Amis								ad, Bowi		aryland		
	Physician /Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each	as a consequ	Ca	ref the mod	-		1	La A	est,		Approximate Interval Betw Onset and De	een eath
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_	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ	ence of)									
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687	ifficate g phy as the	edic		a											
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 ☐ Live birtl 4 ☐ Pregnan 9 ☐ Unknow	n 2 ☐ Fetal It at time of de	death 3	Ectopic pi Other (sp		/	-		23	d. Date of deli Month		ear
о, С	s that ned b deta		Part II Other significant conditions	contributing to death	but not resu	Iting in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco use	e contribute to	the cause of de	ath?
of Vital Records,	w require s been sig should b	Completed by	Harte Ken	1 fa.	Ture						1 □ Ye	es 2	No 3□ Pro	obably 🕊 Ur	nknown
ecc	e law re has be je 2 sho	plet									24a. Was a		24b. Were aut	topsy findings av	vailable
<u></u>	The ate h	ĕ									perform	med?	death? 1 ∐Yes	2. ■No	use of
/ita	sician: The certificate h rector, page	Be	25. Was case referred to medical examiner?						26. Place	of Deat	(Check only or				
£	this light		1 ☐ Yes 2 ☐ №		atient 2 🗆 I				4 ∐ Nu	ırsing Ho	me 5 ☐ Resid	ence 6	Other (Spec	cify)	
	Jing After funer	ation:	27. Manner of Death 1		njury Day, Year)	28b. Time of Injury	M 2	3c. Injury Work 1 □ \	/at ? Yes 2∐I		28d. Describe he	ow injury (	occurred		
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification: To	3 Suicide 6 Could not determine		Injury - At hor etc. (Specify	me, farm, str	eet, factory,	office			28f. Location (S. City or Town		Number or Ru	ral Route Numb	er,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical (	29a. Certifier 1 CertifyIng (Check only one) 2 Medical Ex	Physician: To the be aminer: On the basis and manner	s of examinat	vledge, deatl ion and/or in	h occurred vestigation,	at the tin	ne, date ar pinion, dea	nd place, ith occur	and due to the d red at the time, o	cause(s) a late and p	and manner as place, and due	stated. to the cause(s)	
	To the To the Comp	M	29b. Signature and title of certifier	1					number				signed (Month		_
			Til	105			0	005	763	3	Annapo	Sept	1. 08,	2009	7
$\overline{\wedge}$	1117		30. Name and address of person wh		1 4.	1 -	Print)	11			1.	1	an c	1.4.	
4	Sta	ite	31. Date filed (Month Day Year)	2000 32. R/gi	strar's Signat	ure LCM		m-lc	uny		MUADO	111	111/	21701	

DHMH 17 Rev 1/2001

P.O. Box 68760, of Vital Records, Division

シルーユ State Registrar

Khalid Mahmood, M.D. 31. Date filed (Mor

6 □Could not be

determined

3 Suicide

29a. Certifier

Medical

4 Homicide

29b. Signature and title of certifie



and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D0063233

2 🗌 No

Hagerstown, MD 21742

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

200

			1 - State Registramend #2, 9	State of M <b>9-18-09</b> , pe						lental Hy	/giene Reg. No	TO THE TOTAL	31232
	6		1. Decedent's Name (First, Middle,			HCF	D, al	-		2. Date of De	eath 09:	-13-2009	3. Time of Death
	Physici /Medio		Jean L. Psoras							Septem!	er	2009	5:40 p ^M
-	Examin		4a. Facility Name (If not institution,	give street and number;			4b. City,	Town, or Locat	tion of Death		40	. County of Death	
			Greater Baltim					Towson				altimore	
	Funeral Director		212-28-5293	7. Ag 1  M 2	ge (In yrs. la 79	ast birthday) Yrs.	If Under Months	Days Hou	nde <i>r</i> 24 Hrs. urs Min.	8. Date of Bi (Month, D) 06/15/	1930 1930	9. Birth Cou	place (State or Foreign Intry) MD
	w		Usual Residence of Decedent  10a, State 10b, County		10c. City	, Town or Lo	cation					<u>-</u>	10d. Inside City Limits
	/laryta	ō	MD Baltin	oro	,	Woodl							1 ☐ Yes 2 🙀 No
	the l	rec	10e. Street and Number	DIC		WOOdi	10f. Zip	Code		1	10g. Ci	tizen of What Cou	intry?
	3a o	<b>Funeral Director</b>	1673 Kirkwood B	Peogl				21207			Unit	ted State	es
	items 2	ner	11. Marital Status	12. Was Decedent	Ever in U.S	3. 13.	Was Deced	lent of Hispani ify Cuban, Me	c Origin? (Sp	ecify Yes or N		14. Race - Amer	ican Indian,
980	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, it is the field at Exerciting numbers.	5	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Moivorced	Armed Forces? d 1 □ Yes 2 X If Yes, Give Year or Dates:	No		irres, spec 1 □ Yes 2		ecify:	nicari, etc.)		Black, White,	nite
2-0	2 hou	ted	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usua	I Occupation	most of worki	na	16b. K	(ind of Business/I	ndustry
21215-0036	within 7 iene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)			k done during e retired)	most or work	ng	1774	and i an	
12	should be filed withir and Mental Hygiene. marked other than imatic event, Ire.		17. Father's Name (First, Middle, La	l .			Teach		Anther's Name	(First, Middle		ducation	
Maryland	be d c	Be C	William John La	,						th Dess		r Garriame)	
$\overline{\mathbf{z}}$	s 1 and 2 should I f Health and Men item 27 Is marke other traumatic	은	19a, Informant's Name/Relationshi			19b. Mailir	na Address					or Town, State, Z	ip Code)
	d2		George Psoras J				•				-	City, MD	
ē,	s 1 al		20a. Method of Disposition		20b. Pl	ace of Dispo				Date	T	ocation - City or T	
E	Page nent c int: If		1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			odlawn			09/16	5/2009	Wood	dlawn, M	)
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 8 any Injury or other once.		21. Signature of Funeral Service Li	censee Mi	01044								ily F.H.Inc. MD 21043
			23a. Part 1. Enter the disease, or c	omplication, that cause	d the death							L CILV,	Approximate Interval Between
	Physician	er 1	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each l		Lymph	oma						Onset and Death months
- 15	/Medical Examiner		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Due to (or as	a consequ	ence of):							
		Jer	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequ	ence of):							
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C.									
0,	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):							
68760,	ate b	lica	8	d			-						
		Med	IF FEMALE:	00-16									
O. Box	law requires that the death certifi as been signed by the attending I 2 should be detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal	death 3	☐ Ectopic p ☐ Other <i>(sp</i>					23d. Date of deli Month	very Day Year
σ.	s that ned b	by Pt	Part II. Other significant condition	s contributing to death t	out not resu	Iting in the u	nderlying ca	ause given in F	Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ğ	w requires been sign should be		COPD							1 🗆	Yes 2	Pro 3☐ Pro	obably 4X Unknown
Records,	o _ o	Completed	\ <u></u>				<del></del> -			24a. Was auto perf	opsy formed?	prior to c death?	topsy findings available ompletion of cause of
Vital		0	25. Was case referred to medical					26. F	Place of Death	1 ☐ Yes ∩ (Check only	one)	o 1 □Yes	2 <b>_</b> 0
	S S	To B	examiner? 1  Yes 2 <b>X</b> No	Hospital:	ent 2 🗆 E	ER/Outpatier	nt 3 DC	Othor				6 ☐ Other (Spec	cifv)
	ing Affee une	tion: T	27. Manner of Death  1. Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inj (Month, Da		28b. Time o Injury	f 2	8c. Injury at Work? 1 ☐ Yes		28d. Describe			77.
Division	al or Attending s after death. Il Director: After ed in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of In	jury - At hoi tc. <i>(Specify</i>	me, farm, str	eet, factory			28f. Location City or To	(Street a own, Stat	nd Number or Ru e)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in	edical (	29a. Certifier (Check only one)  17 Certifying 2 Medical E	Physician: To the best xaminer: On the basis and manner si	of examinat	wledge, deat ion and/or in	h occurred vestigation	at the time, da , in my opinion	ate and place, n, death occurr	and due to th red at the time	e cause( e, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	^ A 1			290	. License num	ber		29d. Da	ate signed (Month	, Day, Year)
			Jason	Black	MD			D006119	99		Seg	pt. 14, 2	2009
5	· 00		30. Name and address of person w  Jason Black MD	6701 N C	arla	s Stro	ω+ G	uite A	105 m/	ouzeon	MD 1	21.20/	
	Sta	te	31. Date filed (Month Day Year)	2009 32 segist	rar's Signat	B. A	and d	<u> </u>	100, 10	JWSUII,	עניז 4	21204	
	Registr	ar	OEL TO	LUUU CARRE	~	u. 14	arre						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Ma		artment of Health a rtificate of Death	and Mental Hy	giene Reg. No.	11233
	Dhysisi		1. Decedent's Name (First, Middle, Last)			2. Date of De Month	eath Day Year	3. Time of Death
***	Physici /Medic	al	Harry R. Parks		di Cit. Tour en la setion	Septem	ber 13 2009 4c. County of Dear	
-1	Examin	er	4a. Facility Name (If not institution, give street and number) 328 England Creamery Road		4b. City, Town, or Location of North East	or Death	Cecil	
	Funeral Director		5. Social Security Number 221–14–6959 6. Sex 1. ↑ Age 1. ↑ Age 2. ↑ ↑ Age 2. ↑ ↑ Age 2. ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑	(In yrs. last birthday) 84 Yrs.	If Under 1 Year If Under Months Days Hours	Min. (Month, D	ay, Year) Co	thplace (State or Foreign ountry) irginia
	and ww		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Maryla -f sho	to	Maryland Cecil	North E				1 □ Yes 2 🌠 No
	3a or 28a	al Director	10e. Street and Number 328 England Creamery Road		10f. Zip Code 21901		10g. Citizen of What Co United Stat	
036	be filed within 72 hours after death with the Maryland that Hyglene.  Ad other than "natural", or items 23a or 28a-f show event, the Madical Evaning must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent E Armed Forces? 1 Yes 2 Vi	lo l	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar 1  Yes 2500 Specify:		o- 14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0036	72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during mos DO NOT use retired)	t of working	16b. Kind of Business.	(Industry
212	l within giene. r than "	omo	Elementary/Secondary (0-12) College (1-4or 5-	L)	Operator		B & O Rail	road
nd	be filed tal Hygind of other	Be C	17. Father's Name (First, Middle, Last)		18. Mothe	er's Name (First, Middle	, Maiden Surname)	
ryla	should be and Mental s marked o	2	Hedrick Parks  19a. Informant's Name/Relationship (Type. Print)	10b Mailir	Mary	y Larue	her City or Town State	Zin Code)
Ma	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		Myrtle Parks/Spouse		England Creame		-	
altimore, Maryland	iges 1 and of the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the life in the		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crer	osition (Name of matory or other place)	Date	20c. Location - City or	
Ħ	t. Partmer		4 Donation 5 Other (Specify)  21. Signature Funery Service Licensee	Bayview	Cemetery : 1  2. Name and Address of Facility		North East,	Maryland
Ba	permi Depar Impo any ir	1	21. Signature Trunery Service Licenses	12	7 South Main S	Crouch Fu Street, Nort	neral Home h East, Mary	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin immediate Cause (Final disease or condition resulting in death)  Due to (or as a failure of the condition or condition or condition or cause or condition or cause or condition or cause or condition or cause or condition or cause or condition or cause or complications that caused caused on complications that caused caused caused caused or complications that caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused caused c	the death. Do not ent e.  Mullium a consequence of):		cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	p +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter United lying Cause (Disease or injury	a consequence of):	1 1			
	ecuter and -transi	Examiner	that initiated events c.	coud was consequence of):	rtection			
68760,	ficate be executed physician and s the burial-transit	edical E	d. Ca	of post	itechiar ils glud.			
O. Box (	the death certi by the attending ached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	☐ Ectopic pregnancy ☐ Other ( <i>specify</i> )		23d. Date of de Month	olivery Day Year
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eco	> 10	Completed	herrona of Br	sui		24a. Was	s an 24b. Were a	utopsy findings available completion of cause of
a B	iclan: The lav certificate has ector, page 2:		<b>V</b>				ormed? death?	_i
V.		To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatie	Other:	e of Death (Check only	one) sidence 6 ☐ Other (Spe	acifu)
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Division	To the Hospital or Attending Physicities within 54 hours after death.  To the Funeral Director: After this completely filled in by the funeral directors.	Certification:	a Devisive 6 Decould not be	iry - At home, farm, str <i>(Specify)</i>	reet, factory, office	28f. Location City or To	(Street and Number or Flown, State)	ural Route Number,
	ne Hospits 24 hours ne Funera	ledical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of and manner sta	examination and/or in				
	To the Within To the Comp	Me	29b. Signature and title of certifier  The Cean Ham MD		29c. License number	7	29d. Date signed (Mon	th, Day, Year)
	I		30. Name and address of person who completed cause of do	eath (Item 23a) (Typo	D0487		7/15/	
	)		JUI CHIH HSU M		3 West me	ei St, 7	Alctor L	12 21921
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 6 2009	4 Someth	/			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 16, 2009 8:20 a September Kenneth C. Robertson, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Dayton Glen Hill Assisted Living If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/26/1916 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 M M 2 □ F Months Days TN Director 216-14-0552 92 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a, State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Evantines must be notified at 1 ☐Yes 2 No Director MD Howard Highland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20777 United States Funeral 6749 Cortina Drive death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after XYes 2□No 1941-1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: 2 Specify: White 1945 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Otis Elevator Elevator Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Willie O'Connor Charles W. Robertson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6749 Cortina Drive Highland, MD Gerard C. Robertson - son permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 09/18/2009 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Sign turn of Funeral Service M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Par **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner certificate be executed signed by the attending physician and it is detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 

Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>\$</u> cate has been signification of the category. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 No 1 ☐ Yes 2 INC 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Fother (Spec 1 Yes 2 1 1 10 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

Funeral Director: After this 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 1 🖵 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title 641 30. Name of person who completed cause of death 22 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** MATTIE SHROYER September 20:10M 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SA 215HIK REGIONAL HICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 214-16-2193 Min. 1 □ M 2 KF Hours PA Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show must be notified at 1₽ es 2 No Funeral Director MD SALISBURY Wicomico 10g. Citizen of What Country? 10e. Street and Number Of. Zip Code items 23a or 121801 448 PENN AVE USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 ☐ Never Married 2 ☐ Married ò Specify: WHITE 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Nedical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWNED HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be item 27 Is marked or JACOB SHROYER RACHEL ROSELLA CLITES ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31670 OLD COROLL CHY RD SALLSBURY, MD 91804
ce of Disnosition (Name of Date 20c. Location - City or Town, State NORMA MASSEY daughter Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any injury or c 1 Burial 2 □ Cremation 3 □ Removal from State KKIN Cemeroery 9-17-09 TYASKIN, MD 21865 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility (Jenkonn BOXEI BIVALUE, MIDGISI4 m00416 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final MHEROSCIERO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner So use tindy list or with you if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Duknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deatle? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🖫 No 2 **J**Mo 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manual of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

P.0.

Division of Vital Records.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #23a Per PHYS 9/16/09 CCHDDIC ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Bernice Richards September 11 2009 9:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 12870 Windy Knolls Place Waldorf Charles If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** 6. Sex Months 1 □ M 2 💢 F Yrs. Maryland Director 91 11. 1918 214-60-3127 Sept. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r than "natural", or items 23a or 28a-f sho 1 ☐Yes 2 No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12870 Windy Knolls Place Funeral 20602 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □XNo If Yes, Give Year or Dates Specify White ģ Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home House Wife 7th. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev Norman H. DeMarr ပ <u>Ida Thompson</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7755 Richards Inheritance Pl. La Plata, MD. 20646 ace of Disposition (Name of Date 20c. Location - City or Town, State James Richards/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. Gardens Sept. 16, 2009 Waldorf, MD. 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service m01284 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** + au C8-/Medical Due to (or as a consequence of): Examiner DEMENTIA Sequentially list conditions, Dire to for all a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed SENILE Due to (or as a consequence of): physician a s the burial-1 Box 68760 Physician/Medical as 1 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown been signed by should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 VOnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 1 ☐ Yes 2 ☐ No ∣□Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Deat 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation within 24 hours are: ...

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

5 2009

Baltimore. Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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		1 - State Registrar					Cer	tificat	e of	Death			g. No. 🦢	Udi	JI	<u> </u>
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Examin		4a. Facility Name (		-				4b. City,		r Location of Deat				nty of Death		
		Fort Wa	_					If Under		Washingto		ate of Birth	P		George	or Foreign
Funeral Director		5. Social Security N 244-54-0	611 6614	6. Sex 1 🖾 M 2 🗆		ge (in yrs. i 70	last birthday) Yrs.	Months		Hours Min.	(/	Month, Day,		Nor	th Car	olina
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ylanc Jow		10a. State	10b. County			10c. City	y, Town or Lo	cation					-		10d. Inside C	•
a-fsl	cto	DC							W	ashingto	n				1 <b>K</b> Yes	2 No
or 28	)ire	10e. Street and Nu						10f. Zip	Code		_	10	0g. Citizen	of What Cou	intry?	
ath wi	Funeral Director	2940	Southe	rn Ave.	SE	Apt.				20020					State	S
er deg	nne	11. Marital Status		Arm	Decedent ed Forces?		S. 13. \	Nas Dece f Yes, spe	dent of F cify Cuba	lispanic Origin? (S an, Mexican, Puer	pecify to Ricar	Yes or No- n, etc.)		Race - Amer Black, White		
should be filed within 72 hours after death with the Maryland and Mental Hygiene.  s marked other than "natural", or items 23a or 28a-f show umatic event, it is medical Evanting must be notified at	by F	1 ☐ Never Marr 3 ☐ Widowed		l If Ye	Yes 2 🔀 es, Give rorDates:	No		1 □Yes	2 <b>½</b> No	Specify:			Spe	ecity: B1	ack	
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al Hy other vent,	Be C	17. Father's Name	(First, Middle,	Last)						18. Mother's Nar	ne (Fire	st, Middle, N	Aaiden Suri	name)		
uld b Menta arked atic e	ည	Curt	is Ros	ebure						Verl	ine	Rober	ts			
2 sho and is me		19a. Informant's N					19b. Mailin	ng Address	(Street	and Number or R	ural Ro	ute Number	City or To	wn, State, Z	ip Code)	
and ealth m 27	_3	Matilda		re/ Wi	fe	- 1				Capitol :					WDC 20	0019
ges 1 Fitel or ot		20a. Method of Dis 1 X Burial 2		3 Removal	from State	20b. P	lace of Dispo emetery, cren	sition (Nai natory or c	me of other plac			er	zuc. Locati	on - City or T	own, State	
t. Pa trmen tant:		₩ Donation	5 Other (S	pecify)	A	Ma	arylan				20				larylan	.d
permit. Pages 1 and 2 should be filed within Dispartment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magone.		21. Signature of Fi	ineral Service	Licensee	-PAP	1	1			ess of Facility St				-	20019	)
		23a. Pa t1. Enter	the disease of	complications	that cause	d the death	1							II, DO		
		shock, or hea	art failure. List	only one cause	e on each li	ine.						p ,	,	4	Approxima Interval Be Onset and	Death
Physician / /Medical		disease or condition resulting in death)	on	a	End S ue to (or as			lc Lu	ng D	isease					7 day	S
Examiner							idney I	)i sea	S &						2 yea	rs
4-1	Je	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nditions, nmediate	D	ue to (or as			-1000								
Attending Physician: The law requires that the death certificate be executed refasth.  actor: Attent this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Examiner	that initiated event	S	с	Conge	stive	e Heart	: Fai	1ure	!					2 yea	rs
e exe	Ex	resulting in death)	Last	D	ue to (or as	a consequ	uence of):									
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at the de by the	ysic	1 □ Yes 2 9 □ Unknowr			Unknown	at time or u	iealii 5L	_ Other (s)	becity) _							
that ned b	y Phy	Part II. Other signi	ficant conditi	ons contributing	g to death b	out not resu	ulting in the ur	nderlying o	ause giv	ven in Part I.		23e. Did tol	oacco use	contribute to	the cause of	death?
quires t	d by					_						1 🔀 Y∈	s 2 N	o 3□ Pr	obably 4□	Unknown
aw requir s been s	olete											24a. Was <i>a</i>	n 2	4b. Were au	topsy findings	available
The law cate has page 2 s	Completed											autops perforr 1 □ Yes 2	ned?	death?	_	cause or
ician: T	Be C	25. Was case reference	rred to medica							26. Place of De						
hysicia his cert I direct	To E	1 Yes 2 ∑	No	Hospital:	1 🗌 Inpati	ent 2 🛚	ER/Outpatier			4 LI Nuising I	lome	5 Reside	ence 6 🗆	Other (Spec	cify)	
ding Ph		27. Manner of Dea 1 X Natural	th 5 ☐ Pendir		Date of Inju (Month, Da	ury a <i>y, Year)</i>	28b. Time of Injury		28c. Inju Wor		28d.	Describe ho	ow injury oc	curred		
tendiliterath.	cati	2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could	not be	DI (1)			M		]Yes 2□No	004				I Day to Mo	
al or Attendir s after death. I Director: Aid in by the fu	Certification:	4 Homlcide	determ	nined 28e.	building, et	tc. (Specif	ome, farm, str	eet, factor	у, опісе			City or Towl		umber or Hi	ıral Route Nui	mber,
To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b		29a, Certifier	1⊠ Certifvi	ng Physician:	To the best	of my kno	wledge, deat	h occurred	at the t	ime, date and place	e. and	due to the c	ause(s) an	d manner as	stated.	
e Hos 124 h e Fur	Medical	(Check only one)		Examiner: On		of examina				opinion, death occ						(s)
To th Within To th	Me	29b. Signature and	I title of certifie	r		_		29	c. Licens	se number		2	9d. Date si	gned (Monti	h, Day, Year)	
			1	2	~	1	/_		D	24535			09,	/15/09		
1 1		30. Name and add														
La		Laxmi N.		, M.D.,	F.A.	C.P.		01d	Brar	nch Ave.	Ste	. C-10	Ol C	lintor	, MD.	20735
Sta Registi		SEP 1	7 2009	Benev	U D	A SIGN	alle									

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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sachire Robinson	State of Maryland / Department of Health and Mental Hygiene

Hesachire	Robin		I- For State	tate of Maryla		artment of		ınd Men	tal Hy		Reg. No.	ā0 1123
Ph	nysicia		Registrar  1. Decedent's Name (First, Mid	dle,Last)					- 2	2. Date of De	ath	3. Time of Death
Medical E			Hesachire	Robinson	า					Month Septemb	Day Year er 9, 2009	0849 hrs
1			4a. Facility Name (if not institut				4b. City, Town,	or Location	of Death		4c. County of De	eath
( )			Peninsula Regional I	Mediacl Center			Salisbury				Wicomico	
Fur	neral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y		er 24Hrs.	8. Date of E	Sirth(MM/DD/YYYY) 9.	Birthplace (State or reign
Dire	ector		245-27-8145	1X M 2 F	63	Yrs	Months D	ays Hours	Min.	1-9-		Country) NC
		ŀ	Usual Residence of Decedent									
	апу		10a. State 10b. County	,	10c. City	, Town or Locat	tion					10d. Inside City Limits
la la	show ace.	칟	MD Wico	omico	Sal	lisbur	У					1 X Yes 2 No
faryla	sa-f	Director	10e. Street and Number				10f. Zip Code	е			10g. Citizen of What C	ountry?
the N	a or i	吉	1024 Fairgr	ound Dri	ive		21801				U.S.A.	
with	or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status	12. Was De	cedent Ever in U		as Decedent of					nerican Indian, Black,
death	r iter nust	ij	1 Never Married 2 X	Married Armed F	orces?	lt Y	es, specify Cut	ban, Mexicar	n, Puerto F	(ican, etc.)	White, etc	Ç.
after	ner n	P F	3 Widowed 4 D	vorced If Yes, Give Ye		1	Yes 2X	No specify	:		SpecifyBla	ack
ours	xami	蒙	15. Decedent's Education (Sp	ecify only highest gra	de completed)		nt's Usual Occu				16b. Kind of Busine	ss/industry
6 172 h	a E	mpleted	Elementary/Secondary (0-12	) College (	1-4 or 5+)				aco roure	,,,,		
5-0036 led within 7 Hygiene	ene. Medi	Ĕ	3rd			Labo:	rer				Construc	ction
5-6	d of the	9	17. Father's Name (First, Middl								, Maiden Surname)	
<b>2121</b> 2121 21 buld be fil	arke		Neil Robinso			1406 Mailin	- 444 10:			a Smi	tn umber, City or Town, Si	and Tim Control
D 2	znd N	-1	19a. Informant's Name/Relation		-	10.0						
MD MD and 2 sho	em 2	_	Natalie Robi	nson/wil		Place of Dispos	Fairq Sition (Name of	round	ı pr	LVe,	20c. Location - City	MD 21801 or Town, State
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Pag Pag	ment tant:		4 Donation 5 Other		Di	rect				<u> </u>	9 Dover,	DE
Baltimore, permit. Pages I ar Department of Her	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho jury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Funeral Service	Licensee	2	Bei	Name and Addr Nnie S	ess of Facilit mith	y 91	7 W.	Isabella	st.
	-		2 a. P. H. Enter L. disease, of			Fw	neral	Home	Sa.		ry, MD 21	Approximate Interval
Physi /Med	dical		failure. List only one caus	e on each line.							irest, shock, or heart	Between Onset and
	niner	- 1	Immediate Cause (Final diseas or condition resulting in death)		sclerot		liovascu	ular d	isea	se		Death
)			or condition resulting in death)	Due to (or as	a consequence of	of):						
		<u>ē</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of	of):						1
		튑	cause. Enter Underlying Caus (Disease or injury that initiated	С								
8	ısit	Examiner	events resulting in death) Last	Due to (or as	a consequence of	of):						
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Division of Vital Records, P.O. Box 6876 To the Hospital to Attending Physician: The law requires that the death certificate writin 24 hours after death	y the attending physi hed for use as the bu		IF FEMALE: 23b. Was decedent pregnant in		outcome of preg birth		etal death	3 Ectop	ic pregnar	icv	23d. Date of deli Month	Day Year
<b>× 6</b>	tendir use a	Si	past 12 months?	4 Preg	nant at time of d		ther (Specify)			,		,
Box	the at	ys.	1 Yes 2 No 9 U	nknown 9 Unkr	nown			-				
P.O.	d by		Part II. Other significant cond	itions contributing t	to death but not	resulting in the	underlying caus	se given in P	art I.	-		e to the cause of death?
P. P	certificate has been signed by ector, page 2 should be detach	d by	Cocaine	use						1Y	′es 2 <b>✓</b> No 3	Probably 4 Unknown
rds requ	hould	Completed								24a. Wa		e autopsy findings available to completion of cause of
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<u>~</u>	tifica or, pa		25. Was case referred to medic	al I			26.Pl	ace of Death	(Check o		7 2 110	
/ita /sicia	this certificate	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatien		Other ₄	_	Home 5	Residence 6 0	ther:
Division of Vital Records, and rAttending Physician: The law requirers after death	- E	⊢ŀ	27. Manner of Death	28a. Date	of Injury	28b. Time of	Injury 28c. I	Injury at Wor	k?	28d. Describ	e how injury occurred	
n dia fi	he fur	Certification:		nding	h, Day,Year)		1	Yes 2	No			
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Hospi	Fune Fune	- 1	20a Codifice	Physician: To the be	est of my knowled	ige, death occu	rred at the time	e, date and p	lace, and	due to the ca	use(s) and manner as	stated.
Divisior To the Hospital or Attend	within 24 nours  To the Funeral  completely filled	Medical		aminer:On the basis and manner		and/or investiga	ition, in my opin	nion, death o	ccurred at	the time, da	te and place, and due t	to the cause(s)
E B	8 1 8	₹	29b. Signature and title of certi		Statou.		29c. Lice	ense numbe	г		29d. Date signed	(Month, Day, Year)
				1.11	16		0.	C.M.E.			September 10	0, 2009
		}	30. Name and address of person	n who completed cau	use of death (Iter	n 23a)						
				puty Chief Medi	ical Examine	er 111 Pe	nn Street, E	Baltimore,	MD 21:	201		
	St	ate	31. Date filed (Month, Day, Year SEP 2	32. 5	gistrar's Signat	ture/	wed					
F	Regist	rar	SEP 2	3 2009 1	enem	1. Han	y est					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Sept. 2009 PM MARIE SMITH DORIS 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center Bel Harford Air 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Days Months Hours Min 1 □ M 2 F Yrs. 213-30-7767 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 🔏 No Jarrettsville MD. Harford 10g, Citizen of What Country? 10f. Zip Code 10e, Street and Number United States 2072 Nelson Mill Road 21084 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2M No Specify: 3. Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Blevins Louise Handy Tam Esther 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David S. Smith Still Pond Drive New Freedom, PA. 17349 (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Watters Cem. 9/25/2009 Jarrettsville, MD. William 22. Name and Address of Facility E.G. Kurtz & Son Funeral 21. Signature of Funeral Service Licensee Jarrettsville, Maryland Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) bacterenia mknow Due to (or as a consequence of): Rheumatoid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pheumomediashnem 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: px Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 ☐ Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier (Check only one) and manner stated

Physician/Medical Examiner detached for use as the burial-tran and Records, þ within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be Completed Division of Vital Be Certification: To or Attending Hospital Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

**Funeral Director** 

Completed by

Be

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item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Wedical Examiner must be notified at

permit. Pages 1 and 2 st Department of Heatth an Important: If item 27 is r any injury or other traur once.

**Physician** 

/Medical

Examiner

5-0036

2121

Maryland

Baltimore,

Dons

29b. Signature and title of certifier

29c. License number

September, 23, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive, Bel Air, MD 21014 500 Upper Cheapeake Chnsa

State Registrar

32. Registrar Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 13, Physician/ 2009 Wayne Stevens, Jr. 5:16 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 X M 2 □ F . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Aug. 16, Months Hours **1**956 Maryland Director 213-72-8294 53 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code r must be r ò 10g. Citizen of What Country? Funeral 424 West Franklin Street 21740 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 X Never Married 2 ☐ Married ō þ 1 ☐ Yes 2 X No Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Maintenence Religious Facility Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Stevens, Sr. Dale Wayne Frances Maxine Marshall permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances M. Tennant / Mother P.O. Box 369 Shepherdstown, West Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/17/2009 | Boonsboro, Maryland Manor Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one rause on each line. Approximate Interval Between Immediate Cause (Final MBOLIC STROKE (or as a consequence of): Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the bunal-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the ail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 1 death? this certificate ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No within 24 hours after oeau..

To the Funeral Director: After this c 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined 1 🔍 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

of Vital Records,

Division

DHMH 17 Rev 7/2009

RMAN, MO GHOIN CHAPLES ST, BUITE 4105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 335PM Physician 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICIMICO SAUSBURY KeglONAL BICAL TENINSULUA If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) cial Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 219-07-7928 Usual Residence of Decedent 1 □ M 2 X F Months Days Hours Min 4-20-13 Director Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Mudical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director Somerset Mariland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with Health and Mental Hygiene. 81 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 X No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be arion ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is Kd 20a. Method of Disposition 20b. Place of Disposition cemetery, crematory Date / 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury o 4 Donation Other 2q. Name and Address of Facility al Servic Dannie A Morn's 21. Signature of Fu 2 Harris-Vock Kneral Services Approximate Interval Between Onset and Death k, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. ter the dise 23a. Part 1. 7 r heart fail un Immediat Cause (Final disease or condition resulting in death) **Physician** days Winary /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): physician sthe burial attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Vascular has le 2 s autopsy performed page After this certificate 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Medical Certification: To Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.0. Records, Division of Vital To the Hospital or Attending Physician:

IM

State Registrar DHMH 17 Rev 1/2001 29a. Certifier

29b. Signature and title of certific

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JV.

my

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Penusula

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 3, 2009 Sept. Μ. Short /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Rehabilitation & NursingCir Salisburg Wicomico If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birth **Funeral** 1 □ M 2 🖺 F Months 90 March 23,1919 Illinois Director 322-20-5165 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Madical Evaning must be notified at 1 ☐ Yes 2 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1514 Riverside Drive Ext. Apt. Funeral 21801 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. White Specify: Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Luther Cochran Margaret <u>Brothers</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sally Russum-daughter 3394 Lawsonia Rd. Crisfield, MD 21817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buria! 2 🖺 Cremation 3 ☐ Removal from State Crematory of Delmarva 9/ 15/2009 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Bounds Funeral Home 23a. Part f. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. E Main St Salisbury, MD 21804 Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (cras a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown us ceruncate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 21 No 2 9 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☐ 1√10 Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SFP

William

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robins, M.D. 2000

H.

15

(VIC

29c. License number

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Randy William Sites State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3 Time of Death Month Day Year September 11, 2009 Medical Examiner 1306 hrs Randy William Sites 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 32 Sun Valley Circle Risina Sun Cecil 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Country) Months Days Hours Min Director 214-76-3535 49 Oct. 19, 1959 1X M 2 Maryland Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 Yes 2 X No Maryland Cecil Rising Sun with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 Sun Valley Circle 21911 U.S.A. 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, hours after death Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes White 3 X Widowed If Yes, Give Year Yes 2 X No specify: Divorced Specify ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed Local Union No. 2 during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 72.1 College (1-4 or 5+) other than " Baltimore, MD 21215-0036 Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene ant: If item 27 is marked other than 50 other traumatic event, he Medica Drywall Finisher Twelve Years Philadelphia, PA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Linwood Sites Janice Marie McDonald 19a. Informant's Name/Relationship (Type, Print ) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany Heath (daughter) 319 Ricketts Mill Road, Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State West Chester. Department of Important: R.A. Ferris & Co., Inc. 09/19/09 Donation 5 Other Specify Pennsylvania 21 gnature of Funeral Service License 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. Perryville, <u>Marvland 21903-0766</u> Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line. Between Onset and /Medical a Gunshot Wound of torso Death Immediate Cause (Final disease ₹xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X_{AMENDED} 28a-b, per ME g895 9/29/09 TT UNPENDED attending physician or use as the burial Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Year past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Yes 2 ✓ No 3 Probably 4 Unknown Records, Completed has been s 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? r this certificate h Yes 2 V No 2 No 25. Was case referred to medica 26.Place of Death (Check only one) of Vital æ examiner? Hospital: 1 Other: Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ဂ္ 1 V Yes After th 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28d. Describe how injury occurred Subject shot self Natural

Hospital or Attending Physician: The law requires that the death certificate be Certification: 124 hours after death.
e Funeral Director: A etely filled in by the fu Division within 24 ho

To the Fune
completely fi Medical

Pending Sep 11, 2009 Accident Investigation

FOUND: 1355 hrs

Yes 2 🗸 No 28e. Place of Injury - At home, farm, street, factory, office building, etc.

O.C.M.E.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 32 Sun Valley Circle, Rising Sun, MD

September 12, 2009

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Could not be

determined

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State Registrar

2

3 V Suicide

Homicide 29a. Certifier

32. Registrar's Signature

(Specify) Single Family

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Shama

SHAMA MITTIL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 14816PHV

29c. License number

SICIANS LAWE #152 ROCKVILLE

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 50 M 00 AMIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**/2** M 2□ F Yrs. Director 579-16-1800 88 12/27/1920 DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Experiment by notified at 1X Yes 2 □ No Director Maryland Anne Arundel Annapolis 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code Rm# 3 United States 3023 Annapolis on the Bay Rd. Bld A Funeral 21403 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 African 1 □Yes 2 No Specify ģ 3 XWidowed 4 ☐ Divorced <u>American</u> Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Clerk Government 7 is marked other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental James W. Williams, Sr. Velma Gavin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other troone. Gregory P. Williams/ Son 27 710 Pheasant Drive Forest Hill, Maryland 21050 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation _5 ☐ Other (Specify) Lincoln Memorial 17, 2009 Suitland, Maryland 22 Name and Address of Facility Stewart Funeral Home, Inc. 21. Sign ture of Funera Service Linens e 4001 Benning Rd. NE Washington, DC 20019 23a. Part Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between nset and Death Immediate Cause (Final acuse **Physician** alors disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy õ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy certificate 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 🖪 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 21438

State

DHMH 17 Rev 1/2001

Registrar

Name and address of pers 14-1 MEL

7

DEFENSE

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 To the Hospital within 24 hours at To the Funeral E completely filled in

State Registrar

MO 0U(

120040012

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and addre of person who completed cause of death (Item 23a) (Type, Print)

405 PREDEVICH NOAD, SUITE DY, CATONSULE, MO

COIT 32. Registrar's Signature 31. Date filed (Month, Day, Year)

09-07583	
Howard Barr	

ward Barr		State of Maryland / Department of			2009 3124							
Train a Dairi		1- For State Certificate of		Reg. No.								
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death							
edical Exami	ner	HOWARD NORMAN BARR, JR.	the City Town and acception of Donth	September 28, 2009	2338 hrs							
		4a. Facility Name (if not institution, give street and number) 4117 Kinsway	4b. City, Town, or Location of Death Baltimore		IMORE CITY							
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign								
Director		216-54-6094 XXM 2 F 58 Yrs	Months Days Hours Min	0ct. 5, 1950	Country) Maryland							
		Usual Residence of Decedent										
w any		10a. State 10b. County 10c. City, Town or Locat			10d. Inside City Limits  1 X X Yes 2 No							
fand -f sho	for	Maryland Baltimore City E	Baltimore City T10f. Zip Code	10g, Citizen of								
te Maryland or 28a-f show fied at once.	Director	4117 Kinsway	21206	USA								
with the Maryland ns 23a or 28a-f sho be notified at once.			as Decedent of Hispanic Origin? ( S		ce - American Indian, Black,							
feath w	Funeral	1 Never Married 2XX Married Armed Forces? 1 Yes XX No	Yes, specify Cuban, Mexican, Puerto	o Rican, etc.) Wi	hite, etc.							
after o	by F	3 Widowed 4 Divorced If Yes, Give Yeer 1	Yes 2 XX No specify:	Specif								
2 hours afte "natural", Examiner	ted I		nt's Usual Occupation (Give kind of nost of working life, DO NOT use ret		Business/Industry							
36 hin 72 e. than '	Completed		otive Engineer	Railro	ad Industry							
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Соп	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surna	me)							
21215-0036 ould be filed within 72 d Mental Hygiene. s marked other than "ite event, the Medical	Be	Howard Norman Barr, Sr.		nie Durst	21 ( 7 ( 0 de)							
MD 2' d 2 should th and M n 27 is ma	٩		ng Address (Street and Number or Kinsway Baltim		21206							
		20a. Method of Disposition 20b. Place of Disposi	sition (Name of cemetery,		on - City or Town, State							
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1XX Burial 2 Cremation 3 Removal from State crematory or of		-3-2009   Balti	more, Md.							
Baltin permit. Pr Departmer Importan injury or	ï	4 Donation 5 Other Specify:	Name and Address of Facility	7401 D	lair Rd.							
in Per W	8 8	Tourseld C. Gassam	Lassahn Funeral	Baltimo	re, Md. 21236							
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.		or respiratory arrest, shock, or	Between Onset and							
kaminer	1	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):										
		Sequentially list conditions,  b.										
	iner	If any, leading to immediate Due to (or as a consequence of):										
J	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
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	an/Medical	UNPENDED AMENDED		22d Date	e of delivery							
68760, certificate be nding physici	M/M	nast 12 months?	etal death 3 Ectopic pregr									
Box 687 death certific the attending p	Sici		Other (Specify)									
D, B, the de by the ached f	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use co	ontribute to the cause of death?							
, P.O ires that 1 signed by	d by			1 Yes 2 No	3 Probably 4 Unknown							
of Vital Records, ng Physician: The law require After this certificate has been si neral director, page 2 should be	Completed			24a. Was an 24 autopsy	b. Were autopsy findings available prior to completion of cause of							
Reco The law icate has	dmo			performed? 1 ✔ Yes 2 No	death? 1 ✔ Yes 2 No							
tal Rection: The certificate	Be C	25. Was case referred to medical	26.Place of Death (Chec									
Vit hysici this c	To E	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier		,	6 Other: Scene							
n of ding Pl After funera		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of	f Injury 28c. Injury at Work?	28d. Describe how injury oc	curred							
Division tal or Attendi rs after death. al Director: /	icati	2 Accident Investigation 28e Place of Injury - At home, farm, str.		28f. Location (Street and No	umber or Rural Route Number, City							
Divis pital or At ours after d ieral Direc	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, State)								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur		29a. Certifier Certifying Physician: To the best of my knowledge, death occurrence one)  Medical Examiner: On the basis of examination and/or investig	urred at the time, date and place, an	nd due to the cause(s) and mand at the time, date and place, a	nner as stated. nd due to the cause(s)							
Tot with Tot	Medical	and manner stated.  29b Signature and title of certifier	29c. License number		signed (Month, Day, Year)							
		(Carlolene)	O.C.M.E.	Septem	ber 29, 2009							
10		30: Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Pen	ın Street, Baltimore, MD 21	1201								

Registrar

State 31. Date file SEP 30 2009 32. Registrar's Signature

OCME

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland / Depa	rtificate of Death	/lental Hygle Reg.	000	31243				
	Physicia	n	1. Decedent's Name (First, Middle, Last)	Day Year	3. Time of Death							
	/Medic	al	Gary Lee Bancr  4a. Facility Name (If not institution, give stre		4b. City, Town, or Location of Death	Sept 25	4c. County of Deat	12:45P M				
	Examin	er	Anne Arundel Me	,		Anne Arı						
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Annapolis If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birt	thplace (State or Foreign				
	Director		242-76-2003 1N	1 2□ F 58 Yrs.	Months Days Hours Min.	6-26-19		nsylvania				
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits				
	laryla shov	ō	MD Carroll		Westminster			1 □Yes 2⊠No				
	the N 28a-1 notifie	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	ountry?				
	3a or	i D	1195 Uniontown	Rd.	21158		USA					
	death	Funeral I	11. Marital Status	. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sparity Procedure)  Was Decedent of Hispanic Origin? (Sparity Procedure)	pecify Yes or No-	14. Race - Ame					
36	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a be notified at matic event, its first feath and the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the	by Fu	1 Never Married 2 Married	1 ∑XYes 2 ☐ No If Yes, Give	1 □Yes 2X No Specify:	Thoun, otoly	Specify: wh					
Ş	tural"	q pe	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educat	Ye ar or Dates:	dent's Usual Occupation	161	o. Kind of Business					
5	in 72 n "na	Completed	(Specify only highest grade c	ompleted) (Give	kind of work done during most of work DO NOT use retired)	ring						
212	d with giene ar tha	mo;	Elementary/Secondary (0-12)	College (1-4or 5+)	Lectrician		Electri	cal				
2	al Hy l othe went,	Be C	17. Father's Name (First, Middle, Last)	_		e (First, Middle, Mai	<i>'</i>					
<u> </u>	2 should be and Mental is marked or raumatic ev	2	Harold Eugen			ed Marie						
Mar,	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type Roxanne Fowble Ba		ng Address <i>(Street and Number or Ru</i> 195 Uniontown R							
Baltimore, Maryland 21215-0036	Pages 1 a nent of He ant: if item ary or othe		20a. Method of Disposition 1 ☐ Burial 2 【※Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State 20b. Place of Dispo cemetery, cred South C	osition (Name of matory or other place) arroll Crem. 9-		Location - City or Winfiel	,				
Balti	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee		2. Name and Address of Facility ${ m F1}$							
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between Onset and Death									
	Physician	1										
	/Medical		disease of condition resulting in death)  A. Myocardial Infarction  Due to (or as a consequence of):									
	Examiner	L	Sequentially list conditions b.									
	tisit	Examiner	Sequentially list conditions, if any, leading to immediate cause. E. Liet U. Jarryling Cause (Disease or injury	Due to (or as a consequence of):	9							
8	tificate be executed g physician and as the burial-transit	xan	that initiated events resulting in death) Last	Due to (or as a consequence of):								
68760 <del>,</del> e	e be e	calE	d									
89	tificating phy as the	edical	u			die die ee						
ROX	death cer e attendin d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant		23d. Date of delivery							
O.E		sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown		Month	Month Day Year					
J.	hat the		Part II. Other significant conditions contri	buting to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to	o the cause of death?				
Records,	requires that the been signed by th nould be detache	d by	<b>3</b>		,,	1 ☐ Yes	2 □ No 3 □ P	robably 4 🔀 Unknown				
င္ပ	w required shoul	ompleted		****		24a. Was an	24a. Was an 24b. Were autopsy finding					
Ř	: The law cate has b page 2 sh	dmc				autopsy performed	prior to death?	completion of cause of				
VItal	ician: The lav certificate has ector, page 2	C	25. Was case referred to medical		26. Place of Dea	1 ☐ Yes 2X th (Check only one)	JNo 1 LIYes	s 2 □ No				
	ysici is cer direct	To B	examiner? 1 ☐ Yes 2X No	spital: 1 ☐ Inpatient 2 🛛 ER/Outpatien	Other:	ome 5 ☐ Residenc	e 6 □Other (Spe	ecify)				
Division of	I or Attending Physician: after death. Director: After this certifica in by the funeral director. g	Certification: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?  M 1 \[ \text{Yes} 2 \[ \] No							
/ISI	Atten r deat ector: by the	ifica	a Double 6 Double not be	28e. Place of Injury - At home, farm, str building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
á	al or s afte al Dire	Sert	4 ☐ Homicide determined	rate)								
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (		clan: To the best of my knowledge, deat r: On the basis of examination and/or in and manner stated.								
	Vithin To the comp	Me	29b. Signature and title of certifier	a AA	29c. License number	29d	Date signed (Mon	th, Day, Year)				
			1 HOREL ) NE	W.	D16376	6	7-2610	9				
	nO		30. Name and address of person who comp	pleted cause of death (Item 23a) (Type,			<del> /</del>					
	7		Joseph D Mose	r MD 2001 Me	dical Navy An	napolis,	MD 214	01				
	Sta Registr		31. Date filed (Month Day Year) SEP 3 0 2009	32. Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend tatte of Maryland Avenue and Maryland Avenue and Mental Hygiene Physiciar /Medica

**Examine** 

**Funeral Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Mcdical Evaning context mount be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been

Division of Vital Records, P.O. Box 68760,

	= State Registrar					Certifica	ite of i	Death		F	leg. N	0. 7	LILC	3 1	249		
	1. Decedent's Name	(First, Midd	dle, Last)							2. Date of Dea		Est of Tax	V	3. Time of	Death		
n	Mary Lo	uise I	Burke							Month 09/25/		ay NO	Year	3:56	Рм		
ı				umbar)		4h Cit	y, Town, or	r Location	of Death	09163			y of Death				
	4a. Facility Name (If				or Deali												
	Surburba						ethes		04112:01			ion t	gomer				
	<ol><li>Social Security Nu</li></ol>	ımber	6. Sex	7. Age (In)		Months	er 1 Year s Days	Hours Hours	Min.	<ol> <li>Date of Birtl (Month, Day</li> </ol>	Year	-)	9. Birth	place (Sta <i>t</i> e d ntry)	or Foreign		
	578-56-83	152	1 □ M 2 <b>X</b> F	65	1	rs.	,-			01/15/	194	4	F1	orida			
	Usual Residence of	Decedent															
	10a. State	10b. County	у	10c.	City, Town	or Location							11	10d. Inside Ci			
į	MD	Monte	gomery	C	hevy	Chase							,	1 Yes	2 🗌 No		
3	10e. Street and Number 10f. Zip Code 10g								10a. C	itizen of	What Cour	ntrv?					
5			1 1 // 0								-			-			
3	4/16 Brac	теу г	31vd # T-2				20815					United States					
2	11. Marital Status		Armed F	cedent Ever in orces?	n U.S.	13. Was Dec If Yes, sp	edent of H ecify Cuba	lispanic O an, Mexica	rigin? (Spe ın, Puerto	ecify Yes or No- Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.						
-	1 Never Marrie	ed 2 Ma	rried 1 □Yes	2 No		1 □Yes		Specify									
2	3 Widowed	Divorce	d If Yes, G Year or			I LITES	200	Specify				Speci	fy: Wh:	Tre			
3		15. Decede	nt's Education		16a.	Decedent's Us	ual Occup	ation		T	16b.	Kind of E	Business/In	dustry	_		
3	(Speci	fy only high	est grade completed			(Give kind of w life. DO NOT	vork done o use retired	during mo. d)	st of worki	ng							
Completed by Funcial Director	Elementary/Secon	ary (0-12)	5+	(1-4or 5+)	Но	memakeı	-				Ore	m Ho	m _O				
<i>i</i>	17. Father's Name (	First Middle			110	c.makei		18 Mo#	er's Namo	(First, Middle,							
3																	
2	Milton C.	. Burk	ce					Tere	esa L	yons Bu	rke						
	19a. Informant's Na	me/Relation	ship (Type. Print)		19b.	Mailing Addres	ss (Street	and Numb	er or Rure	al Route Numbe	r, City	or Town	n, State, Zij	p Code)			
	Angel Pet	erson	-Daughter		18	70 Fore	est G	len V	Vav	St. Aug	ust	ine	FL 32	2092			
1	20a. Method of Disp		Paugnter		b. Place of	Disposition (N	ame of	1		ate			- City or To				
	•		3 Removal from	State	cemeter	crematory or	matory or other place)				D.	4600	l 1	MT)			
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Uniferred Se								03/23/2003					Bethesda, MD				
	21. Signature of Funeral Service Licensee										933 Gist Ave. Silver						
	Rapp Funeral & Cremation								ation S	Ser. Spring MD 20910							
7	23a. Part 1. Enter th	e disease, c	or complications that	caused the d	eath. Don	ot enter the me	ode of dyir	ng, such a	s cardiac o	or respiratory ar	rest,			Approximat	e		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final																
	disease or condition		_ a	56	FPS.	1											
	resulting in death)		Due to	(or as a cons	sequence o	rf):											
	0																
5	Sequentially list con if any, leading to imp	nediate	Due to	(or as a cons	sequence o	f):											
	cause. Enter Under Cause (Disease or i	njury	•														
	that Initiated events resulting in death) L	ast	C	(or as a cons	sequence o	f):											
			·														
			d														
1	IF FEMALE:																
L 123h was decedent prednant   L L L L L L L L L L L L L L L L L L									23d. Date of delivery			.,					
								Month Day Y				Year					
2	9 ☐ Unknown		9 □ Unk	nown													
: [	Part II. Other signifi	cant condit	ions contributing to	death but not	resulting in	the underlying	cause giv	en in Part	1.	23e. Did to	bacco	use cor	ntribute to t	the cause of	death?		
									1□∨	1 ☐ Yes 2 ₩No 3 ☐ Probably 4 ☐ Unknown							
In the past 12 months?    Yes 2 No 9 Unknown									о <u>п</u> 110								
<u> </u>									24a. Was an autopsy fin prior to completic				opsy findings	available			
										perfor	med?		prior to completion of cause of death?				
-	25 Mag 2001	ad to						05 5:			2 54	10	1 ∐ Yes	2 <b>1</b> 0			
	25. Was case referre		Hoenital:				Oth	or:		(Check only o							
1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									ify)								
1								28d. Describe how injury occurred									
2 Accident investigation							M 1 ☐Yes 2 ☐No										
	3 Suicide	6 ☐ Could	mined 28e. Plac			m, street, facto	ry, office		1:		(Street and Number or Rural Route Number,						
4 Homicide determined building, etc. (Specify)							City or Town					iwn, State)					
-	29a Cortifior	1 Course	ing Physiolem: To the	a host of m	knowleds -	death accura	nd at the 45	me dete	and place	and due to the	cauco	(e) and -	manner oc	stated			
	(Check only		ing Physiclan: To the Examiner: On the	basis of exan											s)		
	one)			nner stated.													
	29b. Signature and t	itle of certific		1			29c. License number				29d. Date signed (Month, Day, Year)						
	•		a	Pres	010	レり	000	5	112	4	9(28/09						
}	20 Nome and adding									,				f			
	30. Name and addre		n wno completed cal				ori 1 1 a	M	a 20	850							

State

Registrar

31. Date filed (Month, Day, Year)

parke

# Physicia /Medic Examine **Funeral** Director BIRNBADM, ESTAP permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaminar must be notified at once. Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, State Registra

State	State of Maryland	•	rtment of H <i>tificate of L</i>			iene g. No. 📝 🗎	0.0		0 5 0	
Registrar  1. Decedent's Name (First, Middle, Last)		001	integrate of E	- Cutiii	2. Date of Death		110	3. Time of	Death	
ESTHER	E	BIRNBA	MUA		Month SEPTEMBI	Day	Year <b>009</b>	7:00	A ^M	
4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death	1	4c. County	of Death			
GREATER BALTIMOR	E MEDICAL CENT	ΓER	TOWSON			BALT	IMORI			
5. Social Security Number 6. Sex 1 - 40 - 6341	7. Age (In yrs. las 80	t birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth Month, Day, 04/23/19	) ^{Year)}	9. Birthp Coun	lace (State of try) MD	or Foreign	
Usual Residence of Decedent							14	0d. Inside Ci	Arr I Institu	
10a. State 10b. County	10c. City,	Town or Loc	cation				"	ua. Inside Ci 1 <b>X</b> Yes	1	
MD N/A		BAI	_TIMORE						2 🗆 140	
I Oe. Street and Number			10f. Zip Code		10	Og. Citizen of W	Vhat Coun	itry?		
5806 PARK HEIGHTS	AVENUE		212	· -			USA			
11. Marital Status 1 Never Married 2 Married 12	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No		Vas Decedent of Hi f Yes, specify Cuba		pecify Yes or No- o Rican, etc.)	y Yes or No- an, etc.) 14. Race - Am Black, Whi			nite, etc.	
3 Widowed 4 □ Divorced	Year or Dates:		Yes 2 No	Specify:		Specify 16b. Kind of Bu		2		
15. Decedent's Educa (Specify only highest grade)		(Give I	kind of work done d OO NOT use retired,	uring most of wor	king	100. Killa di Bu	15111625/1110	austi y		
Elementary/Secondary (0-12)	College (1-4or 5+) 5+		DANCE COU			EDUCA	TION			
17. Father's Name (First, Middle, Last)	<u> </u>	GOIL	DANCE COU		ne (First, Middle, N					
LEON	RIVKĮI	N	:	BELL			PIRO			
19a. Informant's Name/Relationship (Type	, i	19b. Mailin	g Address (Street a	nd Number or Ru	ıral Route Number,	City or Town,	State, Zip	Code)		
BERNHARD BIRNBAUM	I / SON	3111	BONNIE R	OAD, BAL	TIMORE, I	MD 2120	8			
20a. Method of Disposition		ce of Dispos	sition (Name of natory or other place	)	Date 2	20c. Location -	City or To	wn, State		
1 X Burial 2 ☐ Cremation 3 ☐ Read 4 ☐ Donation 5 ☐ Other (Specify)	moval from State 1 -		IAVAS CHES		5/2009	RANDALI	LSTOW	M . MD		
21. Signature of Funeral Service Licensee		22	. Name and Addres	s of Facility SO	L LEVINS	ON & BR	OS.,	INC.	10	
resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequer  Due to (or as a consequer  Due to (or as a consequer	ice of).	J	<i>y y</i>						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnanc 1  □ Live birth 2  □ Fetal de 4  □ Pregnant at time of dea 9  □ Unknown	eath 3 🗆	Ectopic pregnancy			1	te of delive	,	Year	
Part II. Other significant conditions contr	ributing to death but not resulting	ng in the un	derlying cause give	n in Part I.		s 2 No		he cause of coably 4		
					24a. Was ar autops perform 1 ∐Yes 2	ned,?   c	Were auto prior to co death? 1 □ Yes	psy findings mpletion of c	available ause of	
25. Was case referred to medical examiner?	2-1				th (Check only one	e)				
1 Yes 2 No Ho			t 3 DOA Othe	4 L INUISING	ome 5 Reside	nce 6 Oth	er (Specif	fy)	_	
27. Manner of Déath 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	8b. Time of Injury	28c. Injury Work M 1 🗆	at ? ′es 2 □ No	28d. Describe ho	w injury occurr	red			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (Sti City or Town	reet and Numb , State)	er or Rura	al Route Nun	nber,	
	cian: To the best of my knowle er: On the basis of examination and manner stated.								s)	
29b. Signature and title of certifier	Muie, M	1Φ	29c. License			od. Date signer			200	
30. Name and address of person who com Manshull A. Levi	npleted cause of death (Item 2:	3a) (Type, F	Charles	Street	Suite 2	-05	Tows	ion, M.	D2/2	
SEP 3 () 2000	22. Registrar's Signatur	e d	at I							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per fb 8895 9-30 09 wt/ #19a.perFH, 2896, 1071/09, WS

1- State Amend #11, per Fb g897 11/18/09 TT

Certificate of Death

Reg. No. Print in Black Indelible Ink. Ensure All Copies Are Legible.

#19a.perFH, 2896, 1071/09, WS

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** rouse 2:30A 2009 ar SEPT /Medical 4a. Facility Name (*If not institution, give street and number)*Morningside Assisted Living 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 15 | 1925 | 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1√2 M 2 □ F Carrollton, MD. 84 220 18 3262 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Evant had a use to other traumatic. 1 ☐ Yes 2 No Director Baltimore Baltimore County Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 USA 8800 Old Harford Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 □ No
If Yes, Give
Year or Dates: WW II 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🔀 No Specify 5 Specify: White 3 EXWidowod - 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) John F Fischer Inc permit. Pages 1 and 2 should be filed wit.
Department of Health and Mental Hygien.
Important: If Item 27 Is marked other tha
any injury or other traumatic event, I'm.) Plumber Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie A Bowman Wilfred H Crouse ဂ္ 9a. Informant's Name/Relationship (Tiroe. Print)
Nancy (Lrouse Wife. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8810 Nalther Blvd. Apt. 2319 Baltimore, Maryland 21234 Baltimore, 20a. Method of Disposition

X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Dulaney valley Mem Gdns. 9/29/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 7401 Belair Rd. Signature of Funeral Service Licensee Lassahn Funeral Home Baltimore, Md. 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician unknown Congestive disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner unknows Hypertensi Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont 1 Yes 2 No 9 Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has be irector, page 2 sl 24a. Was an autopsy 1 □ Yes 1 ☐ Yes 2 □No After this certification, funeral director, i 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ector: / by the f 3 Suicide 6 Could not be n 24 hours a... the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 180 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical соmpletely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite Linthicum MI) 31. Date filed (Month, Day, Year) 32. Reps Signature State Registrar

DHMH 17 Rev 1/2001

3

CHARLES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** September 28, arrick 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ohns Hopkins Bayview Medical Center Baltimore 8. Date of Birth (Month, Day, Year) March 31,1954 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🛣 F 212-66-1904 55 Director Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Exprinier matter traumatic an once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21219 USA 14 Barbara Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ∐XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: White δ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Creaden Sr. Jean Creaden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Barbara Lane, Edgemere, Maryland Jason Carrick son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) October 1, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Dundalk, Maryland 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 2110 Sollers Point Road, Dundalk, MD. 21222 n 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listory one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac arrhythma 30 min **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner severe metabolic acidosis if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed septic shock burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Month Day Year 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1 Yes 2 No 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760, 24 hours after deat Funeral Director: filled in by the

Baltimore, Maryland 21215-0036

completely within 2 To the

State Registrar 29b. Signature and title of

and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

29c. License number RES-000 September 28, 2009

d address of person who completed cause of death (Item 23a) (Type, Print)

eneen M. Gifford, MD 4940 Eastern Are Baltimore, MD 21224

31. Date filed (Month, Day,

(Check only one)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 1 per dvr., g895, 09/30/09dhb Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 5:32 PM **Physician** ROSIE CALLIER SEP 2009 _ 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 11/01/1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday Funeral Months Days Hours 1 □ M 2 😿 F 358-16-7361 86 Mississippi Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2X No MD Howard Elkridge Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21075 USA 7305 Maplecrest Road #302 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify. Specify: Black <u>چ</u> 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)

12th grade College (1-4or 5+) Seamstress **Brooks Brothers** of Health and Mental Hygie : If item 27 Is marked other to or other traumatic event, IT other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Davis Mary Elizabeth Lowe ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7305 Maplecrest Road, #302 Elkridge, MD 21075 Jewel Callier - Daughter Department of Health Important: If item 27 any injury or other trong once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Columbia Mem. Gardens 09/19/2009 Columbia, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral 4210 Belair Road, Baltimore, MD 21206 21. Signature of Funeral Service Licensee Cullen Harris per DVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEAR /Medical Due to (or as a consequence of) Examiner ARDIAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine physician and the burial-transit ARTERIAL DISEASE ONARY 0 R Due to (or as a consequence of) aftending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 🛣 ER/Outpatient 3 ☐ DOA 28b. Time of

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Hospital

27. Manner of Death 1 Natural

3 ☐ Suicide

29a. Certifier (Check only one)

5 Pending investigation 2 Accident

6 ☐ Could not be determined 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number 005305

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDAR COLUMBIA MD 21044 LANE Dr. WALTER ATHA 32. Registrar's S nature

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 23,2009 **Physician** 4:50A September Eugene J. Dracy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Joppa 14 Neptune Drive 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** Min 1**X** M 2□ F Months Days Hours 15.1940 Maryland February Director 218-36-4515 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If firem 27 is marked other than "natural" or item—any injury or other trainment. 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location 1 ☐ Yes 2 No Completed by Funeral Director Joppa Md. Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21085 USA 14 Neptune Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2X Married White If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Car Dealership Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lisa Comi Eugene Dracy မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Neptune Drive Spouse Joppa, Md. 21085 Catherine Dracy 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Ki Cremation 3 ☐ Removal from State 09-26-2009 Baltimore, MD Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cirnhosis **Physician** 4890 /Medical Due to (or as a consequence of) Examiner COPD Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy cate has been signed by the atte page 2 should be detached for i in the past 12 months? Day Year 5 ☐ Other (specify) 9 Tunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a. Was an autopsy perform 1 ☐ Yes 2. No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 15 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes neral Director: A death. 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

Box 68760.

P.O.

Division of Vital Records.

State Registrar

Sco 4uber 31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

301 St Paul Place Suite 718 82. Registrar's Signature

20057073

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Mary	•	rtificate of L			g. No. 2011	31255			
			1. Decedent's Name (First, Middle, Las	:t)				2. Date of Death Month	Day Year	3. Time of Death			
	Physicia /Medic		Kathleen F	. David	lson			Septembe	r 25 200	9 11:40 PM			
4	Examin		4a. Facility Name (If not institution, give	street and number)			Location of Death		4c. County of Dea				
-			1112 Will O Brook				sadena		Anne A				
	Funeral		Social Security Number     6. S	ex 7. Age (li ☐ M 2 ☐ F	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)			
и	Director		212-44-0563	_ W 2 X 1	64 Yrs.			May 27	1945	MD			
	and w		Usual Residence of Decedent  10a. State 10b. County	1(	Oc. City, Town or Lo	cation		10d. Inside City Limits					
	laryla i sho	ō		rundel		,	Pasadena			1 ☐ Yes 2 ☑ No			
	28a-	rect	10e. Street and Number	.Fullder		10f. Zip Code	asadena	10	g. Citizen of What Co	ountry?			
	with with	Funeral Director	1112 Will O Broo	k Drive			21122		U	SA			
	ns 23	era	11, Marital Status	12. Was Decedent Eve	er in U.S. 13. \	Vas Decedent of Hi fYes, specify Cuba	ispanic Orlgin? (Sp	ecify Yes or No-	14. Race - Am				
(0	filed within 72 hours after death with the Maryland Hygiene. viter than "natural", or items 23a or 28a-f show ant, the Madical Everniner must be natified at	Εū	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐Yes 2 ☑ No			in, Mexican, Puerto Specify:	Hican, etc.)	Black, Whit	e, etc. Nhite			
21215-0036	al",o	by	3 🔀 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 ☑ No	эреспу.		Specify: V	VIIICE			
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21	2 should be filed within 7 h and Mental Hygiene. 7 is marked other than " rraumatic event, In. "Mental or and other than "	dr.	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. I				**	1 1 2			
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nd	be fil ntal ⊢ id otl ever	B	17. Father's Name (First, Middle, Last)										
<u></u>	ould I Mer narke	မ	Sidney A.	Smith	405 14-15	- Address (Chrost	Lydia	Will	Lard City or Town, State,	Zin Code)			
Maryland	12 sh th and 7 is n traun		19a. Informant's Name/Relationship ( Brian C. Smith	(son)		,			dena, MD 2				
	s 1 and 2 of Health of item 27 is		20a. Method of Disposition		20b. Place of Dispo			Date 2	Oc. Location - City of				
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Baltimore,			4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Liber			en_Cemete  2. Name and Addres				e, Maryland			
Ba	permit. Departr Importa any inju		21. Signature of 1 diferal Service Elder	Z V )				-	ena, MD 21	Home, P.A.			
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	Physician /Medical		disease or condition resulting in death)	a. Due to (or a ta c						13 100.000			
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Вох	th ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	☐ Ectopic pregnanc	у		23d. Date of d Month	elivery Day Year			
0.	The law requires that the death cert ate has been signed by the attendin age 2 should be detached for use a	Physician/N	1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant at tir 9 ☐ Unknown	me of <b>de</b> ath 5[	Other (specify)							
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o	ding F h. After funera	ië E	1 Natural 5 Pending 2 Accident investigatio	(Month, Day, Y		Wor	k? Yes 2 □ No						
Division of	l or Attending Physician: after death. Director: After this certifica d in by the funeral director, p	fica	3 Suicide 6 Could not b	e 28e, Place of Injury	At home, farm, st	reet, factory, office				Pural Route Number,			
<u>S</u>	after after Dire	Certification: To	4 ☐ Homicide determined	building, etc.	(Specify)			City or Town	n, State)				
_	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	al C	29a. Certifier 1 Certifying P	hysician: To the best of	my knowledge, dea	th occurred at the ti	me, date and place	e, and due to the c	ause(s) and manner	as stated.			
	he Hk in 24 he Fu pletel	Medical	(Check only 2 Medical Exa	miner: On the basis of each manner state		ivestigation, in my o	opinion, death occu						
	Vith To t	Σ	29b. Signature and title of certifier	0		29c. Licens	se number	Co	9d. Date signed (Mo	nth, Day, Year)			
			, (man	and wil	ン	D.7.	1505	X	plenser	20, 200-1			
			30. Name and address of person who		ith (Item 23a) (Type,	Print)	Dry Cit	en Au	mie 1	28, 2009 21061			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. 29 Day 2009 Year **Physician** 1:50 P M Durbin Norman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 428 Bostonian Way Harford Havre deGrace If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 11/08/1924 1 X M 2 □ F Months Days Hours Min. Indiana 84 Director 317-18-6343 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mertal Hygiene. In the Mertal Hygiene wit: If tem 27 is marked other than "naturel", or items 23a or 28a-f show any or other traumatic event, the Merical Experiment mat be notified at any or other traumatic event, the Merical Experiment mat be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 ☐Yes 2 XNo MD Harford Funeral Director Havre deGrace 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 428 Bostonian Way 21078 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2X No White Specify Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Molding Machine General Motors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emil Durbin Alta Abbott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any injury or other trau Judy Tower, Daughter 428 Bostonian Way, Havre deGrace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Miller Cemetery 10/05/2009 Shelby Co., Indiana 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune at Service Licensee 22. Name and Address of Facility Glenn E. George & Son FH T. Harman 180 437 Amos Road, Shelbyville, IN 46176 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DEMENTIA ENDSTAGE disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, ettending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ FAILURE TO THRIVE, HYPERTENSION 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed ATRIAL FIBRILLATION, HYDROCEPHALUS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 □ Yes 2 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 1 Nursing Home | 5 \( \text{Residence} \) Residence | 6 \( \text{Other} \) Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours at 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

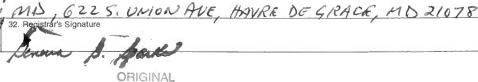
31. Date filed (Month, Day, Year)

DHA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NJANI

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [11] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 20,16 FM John Dewald 09 27 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bayview Johns Hoskins Medred Center Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**⊠** M 2□ F 217-14-0144 87 7-14-1922 Maryĺand Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Exercises must be notified at 10d. Inside City Limits 10a State 10c. City, Town or Location ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2X No Dundalk Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 7400 Kirtley Road 21224 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No WWII 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Army White 1 ☐Yes 2 X No Specify ð 3 Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City Hospital Painter 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dewald Finn George Mary Ellen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7400 Kirtley Road Baltimore, Maryland John M. Dewald Jr. - Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Oak Lawn Cemetery 10-3-09 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. F. H. 21. Signature of Funeral Service Licenses 263 S. Conkling Street Balto. Md. 21224 0 23a. Part 1. Enter the disease or com shock, or heart failure. List only Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Cardiogeniz shock Min **Physician** /Medical Due to (or as a consequence of): Examiner ventricular tibrillatter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine 10 years law requires that the death certificate be executed 15 Chemoz heart Chronic and -tran Due to (or as a consequence of) attending physician a for use as the burial-Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 September 27,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Ryan Childers, MD

31. Date filed (Month, Day, Year)

4940

32. Pigistrar's Signature

ORIGINAL

Eastern Avenue Baltimore, MD

			For State Registrar	State of	Marylan	-	artment <i>rtificate</i>				-	gien Reg. N	6 000	Page 1	N 1 2 5 B
			1. Decedent's Name (First, Middle, La	ist)							2. Date of De Month	ath	E100 100 10		3. Time of Death
	Physici /Medi		William Henry	Lueders I	ornett	ce					Septembe	r 2	200 g	9	10:40 A M
	Examir	ner	4a. Facility Name (If not institution, given 9716 Hill Street	e street and numb	oer)		4b. City, T		Location singt				c. County of I		У
	Funeral Director		5. Social Security Number 6. 9408-66-9989	Gex 7. 1 X M 2 □ F	Age (In yrs. 87	la <i>st birthd</i> ay) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Month De June 22,	th 1/22	2 0	Birthp Coun <b>h1</b> 0	lace (State or Foreign try)
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9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evantium rust be notified at once.	d by Funeral Directo	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Dyes 2 If Yes, Give Year or Date	ent Ever in U.ses? □ No es:1945—1	949	Vas Decede fYes, specil I □Yes 2		ispanic Or n, Mexica Specify.		cify Yes or No Rican, etc.)	-	14. Race - Black, V	Vhite, e	etc.
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Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of building,	Injury - At hor etc. (Specify	me, farm, stre	et, factory, o	office		2	8f. Location (S City or Tox	Street a	nd Number o	r Rura	l Route Number,
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	25+1		30. Name and address of person who David Edward Roge					Veni	1e. #	1400	Chevy	Cha	se. Ma	rv1	and 20815
	Sta	te	31. Date filed (Month, Day, Year)	AD	strar's Signat			7 - 111	, "	- 100	J.I.C V y	- III	, 11a	- y -	

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 2009 Year **Physician** 10:44 A M 25, Marcelle V. Davis September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) 1 □ M 2 🛣 F 87 May 20, 1922 France 577-42-2360 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examinat must be notified at any injury or other traumatic event; the Medical Examinat must be notified at any once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1X Yes 2 No Directo Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12803 Atlantic Avenue 20851 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Never Married 2 ☐ Married □Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: 3 Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Cleaning 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Unkown) (Unkown) Bonon ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12803 Atlantic Avenue, Rockville, Maryland 20851 Steven Davis/Son 20b. Place of Disposition (Name of cemetery crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition September 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 28, 2009 4 □ Donation 5 □ Other (Specify) Crematorium, Inc. Bethesda, Maryland 21. Signatur of Funeral Service Robert A. Pumphrey Funeral Home/Rockville, Inc. M01530 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Arteriosclerotic Coronary Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed after death. physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day 5 ☐ Other (specify) 1 ☐ Yes Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation reral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in 29a. Certifier 1 ី Certifying Physlcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D54776 September 25, 2009 ess of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 Barton Leonard, M.D. 31. Date filed (Month, Day, Year) 32. Registrar' Signatu State SEP 3 0 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7:00 A M **Physician** SEPT. 27, 2009 NICHOLAS ANTHONY DePALO, SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A BALTIMORE 6406 FAIRDEL AVE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, JAN . 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours MD 87 Director 214-14-8225 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 Yes 2 No Director BALTIMORE N/A MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7 USA 21206 6406 FAIRDEL AVE Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items the Medical Examiner me 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygione. mt: If Item 27 Is marked other than "natural", or ite nry or other traumatic event, the Medical Examine in 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation. 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SELF EMPLOYED Elementary/Secondary (0-12) College (1-4or 5+) DEPALO & SONS SALES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY INGOGLIA ONOFRIO DePALO 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau BALTIMORE, MD 21206 6406 FAIRDEL AVE GERTRUDE DePALO-WIFE Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/3/09 BALTIMORE, MD GARDENS OF FAITH 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MILLER-DIPPEL FUNERAL HOME, INC BALTIMORE, MD 21206 6415 BELAIR RD Approximate Interval Between Onset and Death 23a. Part1 Enter the se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. shock, or heart failure Immediate Cause (Final **Physician** PNeumonia 4 Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to instruct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical the as IF FEMALE: use 23c, If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ed by the atter in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Syndrome 24a. Was an page 2 autopsy perform 2 No or Attending Physician: uneral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 3□ DOA 2 ER/Outpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 🛂 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0037155

State Registrar

parks

Bldg 5601 Loch Raven BlvD

moryland 21239

Name and address of person who combated cause of death (Item 23a) (Type, Print)

MD

31. Date filed (Month)

206 Russell Morgan

32 Registrar's Signature

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

backs

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3:30 स्मिक्ट्रेट्टिंड देंदिन **Physician** James Michael Daniel /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hechthe VA Meryland are System If Under 1 Year | Alf Under 24 Hrs. 8. Date of Birth 05/03/1949 Birthplace (State or Foreign Country)
 MD Social Security Numb Age (In yrs. last birthday) **Funeral** Days Min Hours 212-48-8600 60 MD Yrs **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show or than "natural", or items 23a or 28a-f show the Medical Examinar is ust be notified at 1 ☐ Yes 2 No MD Funeral Director Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1302 Harford Square Dr. 21040 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 Das 2 DNo
If Yes, Give Vietnam
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Restuarant Ith and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Short Order Cook other traumatic event, 17. Father's Name (First, Middle, Last)

James Clyde Daniel 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event once. Be Gladys Marie ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print)
Bobbye T. Helfand/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16~Canvas~Pl.~Bel~Air,~MD~2101520a. Method of Disposition

1 □ Burial 2 □ Gremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 29, Sept. Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facilitation P.A. Stephen D. Lohrmann P.A. 21. Signature of Funeral Service Licensee Green Pastures Dr. Balto, MD 23a. Part 1. Her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** UNKINOWN /Medical Due to (or as consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dut to (or as a consequence of) Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4) Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Yes 2 this certificate 1 ☐ Yes 1 Tyes funeral director, Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of al or Attending P s after death. 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State SEP 3 0 2009 Registrar

DHMH 17 Rev 1/2001

			1 – For State Registrar		te of Ma	aryland	-	artment rtificate			and M	lental Hyg	iene eg. No.	<u> 1119</u>	ď	263
- 1	Physici	an	1. Decedent's Name (First, Mid		•							2. Date of Dea Month	Day	Year 2009	3. Time of	Death M
	/Medic Examir		Patricia Ott  4a. Facility Name (If not institut	-				4b. City, 7	own, or	Location of	of Death	Septemb		y of Death	4:20P	
	LAdilli	iei	4606 Ball Gar	_	ŕ			Not	ting	gham				Balto	•	
	Funeral Director		5. Social Security Number 215-42-2125	6. Sex 1 □ M 2X	TE	e (In yrs. Ia 65	st birthday) Yrs.	If Under Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day April 4	Year) ,1944	9. Birth Cou M	place <i>(Stat</i> e o ntry) arylanc	r Foreign 1
	land ow		Usual Residence of Decedent  10a. State 10b. Coun	ty		10c. City,	Town or Lo	cation							10d. Inside Cit	ty Limits
	Marylan a-f show	ţċ	Md.	Balto.				Not	ting	gham					1 ☐ Yes	2X No
	ith the Ma or 28a-f	Director	10e. Street and Number					10f. Zip	Code			1	0g. Citizen of	What Cou	ntry?	
	sath w		4606 Ball Ga		D		140.1	l Boot I		21236				USA		
920	filed within 72 hours after death with the Maryland Hygiene. viher than "natural", or Items 23a or 28a-f show ant, It a Masilcal Examinar mast be recified at	by Funeral	11. Marital Status  1 □ Never Married 2 ▼ Marital Status  3 □ Widowed 4 □ Divorce	Arm arried 1 ☐ If Ye	S Decedent E led Forces? Yes 2 ☑ es, Give ir or Dates:			Was Decede fYes, speci I∐Yes 2				ecify Yes or No- Rican, etc.)		ack, White,	can Indian, etc. ite	
Baltimore, Maryland 21215-0036	72 hours "natural" olical Ex	Completed	15. Decedo (Specify only high	ent's Education lest grade compl	eted)		(Give	dent's Usual kind of work	done d	urina mos	t of worki	ina i	16b. Kind of E	Business/Ir	ndustry	
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<b>d</b> 2	should be filed withind Mental Hygiene, marked other than matic event, It and	Be Co	12th 17. Father's Name (First, Middl	e, Last)			Medica	ar kec				e (First, Middle, I			an on	ice
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/Jar	m w =		19a. Informant's Name/Relation				19b. Mailin	g Address	(Street a	nd Numbe	er or Rur	al Route Numbe	r, City or Town	n, State, Zi	p Code)	
e,	1 and 2 Health a tem 27 is		Vincent Fert 20a. Method of Disposition		Spou	20b. Pla	ace of Dispo	5 Ball	e of			Notting Date	ham, Mo 20c. Location			
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alti	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service			10		. Name and	Addres			chimunek				
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٦	Physician /Medical		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	st only one cause	e on each lin	cud	ial	er the mode	of dying	h iv	cardiac	or respiratory arr	est,		Approximate Interval Betv Onset and D	veen
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о. С.	s that ined b e deta	by Pr	Part II. Other significant condi	tions contributing	g to death bu	ut not result	ting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco use cor	ntribute to	the cause of de	eath?
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Vita	ician: certific ector,	Be	25. Was case referred to medic examiner?	al Hospital:								n (Check only on				
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ision	Attending death. ctor: Afte y the fune	Certification: To	1 ☑ Natural 5 ☐ Pend 2 ☐ Accident inves 3 ☐ Suicide 6 ☐ Could	tigation I not be	(Month, Day		Injury	М		? ′es 2 🔲 i	No	28f. Location (S			ral Route Numl	her
οį	al or / s after al Dire	Serti	4 ☐ Homicide deter	mined 200.	building, etc	:. (Specify)	,	, <b>,</b> ,				City or Town	n, State)	.201 01 1101		2011
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 and 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to	Medical (	29a. Certifier 1 Certify (Check only one) 1 Medica	ing Physician: il Examiner: On and	To the best of the basis of I manner sta	examinati	rledge, death on and/or in	occurred a vestigation,	at the tim in my op	ie, date ar pinion, dea	nd place, ath occur	and due to the or red at the time, o	ause(s) and r late and place	manner as , and due	stated. to the cause(s)	)
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	20		30. Name and address of person		20 Si		zda) (Type, I	Print) Dr.	#1	105	Tou	vson,	MA	21	204	
	Sta	te	31. Date filed (Month, Day, Yea		32. Registra	· · /	ire 1	00	17 '	-1-	, -	/	v · 1)		- /	

DHMH 17 Rev 1/2001

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760%

		1 - For State Registrar	State of Mary		rtment of Healt <i>tificate of Dea</i>		ntal Hygien Reg. N	- 9 0 0 0 0	31264
Physicia /Medic		1. Decedent's Name (First, Middle, Patricia					Date of Death Month ptembe:	r ² 29 <b>,</b> 200	3. Time of Death  9 1:44 AM
Examin		4a. Facility Name (If not institution, 808 Creek Roa	ıd		4b. City, Town, or Location  ESSEX  If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Year   If Under 1 Y			c. County of Death	
Funeral Director		5. Social Security Number 219-28-1899  Usual Residence of Decedent	6. Sex 7. Age (In 1	yrs. last birthday) 7 Yrs.	Months Days Hou	urs Min. At	Month, Day, Yea	1932 ซึ่ง	antry)
e Maryland a-f show	ctor	10a. State 10b. County	timore 100	c. City, Town or Loc Mic	ation ldle River	•			10d. Inside City Limits 1 □ Yes 2 No
th with the 23a or 28	Funeral Director	10e. Street and Number 9708 Matzo	n Road		10f. Zip Code 21220		10g. 0	Citizen of What Col	untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 \( \superset Yes \) No If Yes, Give Year or Dates:	1		ecify:	/Yes or No- an, etc.)	14. Race - Ame Black, White Specify:	
within 72 hc ene. <b>than "natu</b> i	Completed by	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 12	s Education grade completed)  College (1-4or 5+)	<b>I</b>	lent's Usual Occupation kind of work done during DO NOT use retired) nemaker	most of working	16b.	Kind of Business/I	ndustry Home
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and 2 shou saith and M 1 27 is mar er traumat		19a. Informant's Name/Relationsh Alan Felts/		19b. Mailin 714	g Address (Street and No Dld North	umber or Rural R Point			
Pages 1 ament of He ant; If iten jury or oth		20a. Method of Disposition 1 ☑ Buriah 2 ☐ Cremation 4 ☐ Doyation 5 ☐ Other (Sp	3 ☐ Removal from State ]	_	atery or other place)	10/02	/09   Ba	Location - City or altimore	e, MD
permit Depart Import any inj		21. Signature of Funeral Service L	icensee Hollo	C C	Name and Address of Fonnelly FU	Jneral	Mace Ay Home of	enue Ba Essex	2122 ^{MD}
Physician /Medical Examiner bhysician and sthe purial-transit	al Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a cor	nsequence of):	artery c cardic	disco mell	se polh itus	1	Interval Between Onset and Death
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The law racate has be page 2 sh	Completed						24a. Was an autopsy performed 1 □Yes 2	prior to death?	utopsy findings available completion of cause of
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be	25. Was case referred to medical examiner?  1   Yes   2   Web    27. Manner of Death  1   Natural   5   Pending investig  3   Suicide   6   Could n determi	28a. Date of Injury (Month, Day, Yea		t 3 □ DOA Other: 4 [ 28c. Injury at Work?  M 1 □ Yes	2 No	5 ☐ Residence	and Number or Ri	ural Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir.	Medical Co	29a. Certifier 12 Certifying (Check only one)	g Physician: To the best of my xaminer: On the basis of exa and manner stated.	y knowledge, deatl amination and/or in	n occurred at the time, da vestigation, in my opinion	ate and place, and n, death occurred	d due to the cause at the time, date	e(s) and manner a and place, and due	s stated. e to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	Har	- · M {	29c. License num	949	29d.	Date signed (Mont	h, Day, Year)
Sta Registr	-	30 Name and address of person of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second	vho completed cause of death  A. Bout at ZiS  32. Registrar's 5	mb.	8113 Harfo	ord Rd.	Suite 100	Batto. 1	MD. 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 7:20 P^M Avon 9 24 2009 Reginald Franklin /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center Towson Balto If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 9-8-1938 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. **X**□ M 2□ F MD 71 212-34-9015 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location show 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinator must be notified at 1 ☐ Yes 2 ☐ No Director MD Balto Parkville 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number with 4 Spindrift Circle Apt 21234 U SA Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MD City School bus Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) System Self Employed 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary E. Lewis Riley R. Franklin ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4 Spindrift Circle Apt C Parkville, MD 19a. Informant's Name/Relationship (Type. Print) Betty Franklin-Wife other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any injury or conce. ō 1 Surial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Pk 10-5-2009 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee North Avenue Balto, MD 1101 E. Waren 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METHSTATIC MONTHS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) signed by the a I □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HUSFICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 X Natural 5 ☐ Pending investigation ours after death.

leral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide the Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 NORTH CHARLES ST, SUITE 4105 BALTIMORE, ND 21204 DANIEUE DOBEFMAN , MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar SEP 3 0 2009

Please Type or Print in Black Indelible Ind. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 28, 2009 5:49 A M ANN C. GORDON 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR 8. Date of Birth (Month 102), Year) FEB. 2, 1928 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number 217-22-9990 81 ILLINOIS Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 □Yes 2 No **OVERLEA** BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 440 OLD HOME RD 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No WHITE Specify: Specify: 3 X Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EDWIN WALKER CHARLOTTE SCHULTE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FALLSTON, JOANN MAYR-DAUGHTER 1706 ARABIAN WAY MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 10/2/09 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC BALTIMORE, MD 21206 6415 BELAIR RD pile it is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause in the fine. 23a. Part 1. Enter the disease shock, or heart f Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 weeks

Examiner attending physician and for use as the burial-tran Records, P.O. Box 68760 of Vital Division

**Physician** 

/Medical

**Physician** 

/Medical

**Examiner** 

10a. State

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Medical

**Funeral** 

Director

Baltimore, Maryland 21215-0036

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):	remic Pu	rpure Years
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Thromboglip	contributing to death but not resulting in the underlying cause given in Part I.  ON 5  In patture The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules of Experies Part  The rules Part  The rules of Experies Part  The rules of Experies Part  The		
25. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one)	
1 Yes 2 No	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	lome 5 ☐ Residence	6 ☐ Other (Specify)
27. Manner of Death 1		28d. Describe how in	ury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ite)
	nysician: To the best of my knowledge, death occurred at the time, date and plac niner: On the basis of examination and/or investigation, in my opinion, death occ		

chesapeake Drive Bei Air, mD 21014

State Registrar NNENNA U 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

200 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 25 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MUNIUM 7. Age (In yrs. <u>la</u>st birthday) 9. Birthplace (State or Foreign **Funeral** Country) NY Director 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Tyes 2 No altimore Timonium 10e. Street and Number 10g. Citizen of What Country? Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? 1 X Yes 2 If Yes, Give W Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or i any injuy or other traumatic event, the Medical once. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Sparrows Point College (1-4 or 5+) Elementary/Seconday (0-12) Shipyard Naval Architect Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Joseph Gray Catherine Agnes Lennox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, John Gray/Self 2300 Dulaney Valley Rd. Balto, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Septe. 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Beltsville, MD Chesapeake Crem. 4 Donation 5 Other (Specify) 2009 22. Name and Address of FaciGAFA/Stephen 21. Signature of Funeral Service Licensee D.Lohrmann 8717 Green Pastures Dr. Balto, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (of as a consequence of) Exami ending physician and use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? for Year Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Harial Abrillation Records, 1 Yes 2 No 3 Probably 4 Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has Sclerodema page the Hospital or Attending Physician: The performe 2 No Yes 2 N 1 Yes 25. Was case referred to medica Division of Vital 26. Place of Death (Check only one) Be Other: 2 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 2 No Accident Suicide Investigation 1 Yes 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 7/2009

Business Center Dr. Reisterstown, MD21136

ddress of person who completed cause of death (Item 23a) (Type, Print)

			_ POI	epartment of Health and N Certificate of Death		glene Reg. No. 2019	3126
	Physici	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Dea		3. Time of Death
	/Medi		Kenneth M. Hume		Septemb	er ^{Day} 6,2009	7:10P M
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
2.4			Stella Maris	Timonium  day)   If Under 1 Year   If Under 24 Hrs.	D Data of Digit	Balto.	lace (State or Foreign
- 18	Funeral		5. Social Security Number  6. Sex  7. Age (In yrs. last birth	Months Days Hours Min.	8. Date of Birth (Month, Day	r, Year) Coun	try)
	Director		217-22-6087 Usual Residence of Decedent		Novembe	r 25,1928 Pe	nnsylvania
	yland		10a. State 10b. County 10c. City, Town	or Location		1	0d. Inside City Limits
	Mar-fst	ş	Md. Balto. White	e Marsh			1 □Yes 2 🛣 No
	th the	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Coun	try?
	th wit		5311 Bangert Street	21162		USA	
	ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e	
36	or it	by Fi	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:			ite
Ö	hours ural		3 □ Widowed 4 □ Divorced Year or Dates: 1951–19	53 Decedent's Usual Occupation		16b. Kind of Business/Inc	
5.	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examinar must be notified at	Completed	(Specify only highest grade completed)	Give kind of work done during most of work life. DO NOT use retired)	king	100. Killd of Busiless/life	ausii y
12	withi	l mo		es Management		Food	
b	if Hyg other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle,	Maiden Surname)	
ĭar	Aenta Aenta rked tic ev	To E	Melvin Hume	Marie Dw	ver		
P.	short short		19a. Informant's Name/Relationship (Type. Print) 19b. I	Mailing Address (Street and Number or Ru	ral Route Numbe	r, City or Town, State, Zip	Code)
Z .	and 2 ealth n 27 i	10		311 Bangert Street	White 1	Marsh, Md. 2	1162
7:10~P.M. altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantina must be muffled at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State  20b. Place of I cemetery.	Disposition (Name of crematory or other place)	Date	20c. Location - City or To	wn, State
Ë.	Pag ment lant:		4□Donation 5□Other (Specify) Bayvie	ew 10-01	-2009 1	Baltimore, M	d
Ball	permit Depar Impor any in once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sc	himunek	Funeral Hom	e
	₽U <b>=</b> 8 0		Buen Gille	9705 Belair		ttingham, Md	
	Physician /Medical Examiner		resulting in death)  a.  Due to (or as a consequence of	· O Vascular V.	/	631,	Approximate Interval Between Onset and Death
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6009 <del>6</del>	ficate be executed physician and s the burial-transit	edical Exa	Due to (or as a consequence of d	):			
26, 2 <b>D. Box</b>	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day <b>Ye</b> ar
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HUME of Vi	hysion this co	.0	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp		ome 5 ☐ Resid	ence 6 ☐ Other (Specif	y)
	ding Physician: The th. th. After this certificate his funeral director, page	tion:	27. Manner of Death  1 Actural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Year)	me of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe h	ow injury occurred	
KENNETH Division	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: T	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (S City or Tow	treet and Number or Rura n, State)	l Route Number,
×	Hospita 24 hours Funera etely fille	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place /or investigation, in my opinion, death occu	, and due to the rred at the time,	cause(s) and manner as s date and place, and due to	stated. the cause(s)
	omple	Mec	29h Signature and title of certifier	29c. License number	, 2	29d. Date signed (Month,	Day, Year)
			Makhuda on 7	2 155	0 %	SEPTEMBER 2	28, 2009
	14,		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)			
	le		EDDIE NAKHUDA, M.D. 2300 DULANE		NIUM, MD	21093	
	Sta Registr		31. Date filed (Month, Day, Year) 52. Registrar's Signiture	arket			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month 2:58 p. <u>Patricia Evelyn Harris</u> Medical September 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice **Baltimore** Social Security Number If Under 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min (Month, Day, Year) 1 □ M 2 🛛 F Director Yrs 217-50-6682 11-12-19/17 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MDBaltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8531 Brest Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No *Specify: Specify: African-American If Yes, Give Year or Dates 3 🔀 Widowed 4 🗆 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) P.H. Floor Surgeon Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry J. Harrell Rosezelia Pembroke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tonda Hill/Daughter 8531 Brest Road, Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ ponation 5 ☐ Other (Specify) Metro Crematory 9-30-09 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie funeral Home P.A. of Balto. Co. MANCON Randallstown MD 21133 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner rars Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 WNo Month Day Pregnant at time of death the signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn 24 hours after death.

Funeral Director: After this certificate 2 1 🗌 Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဥ 2 No Other Gilchrist 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Investigation 6 Could not be 1 🗌 Yes 2 No Accident Suicide Place of Irijury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701

32. Registrar's Signature

Bus 2

31. Date filed (Month, Day, Year) SEP 3 0 2009

09-07531	
Kathy Hall	

athy Hall	State of Maryland / Department of 1-For State Registrar  Certificate of		Reg. No. 2009 3127
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	of Death Sember 27, 2009 3. Time of Death O028 hrs	
	4a. Facility Name (if not institution, give street and number)  4	b. City, Town, or Location of Death  Nottingham	4c. County of Death Baltimore County
Funeral	9016 Deviation Road  5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday)	If Under 1 Year   If Under 24Hrs.   8. Date	of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	218-44-7941 _{1 M} XX 64 Yrs.	Months Days Hours Min. 08/	18/1945 Foreign Country) MD
any	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Locati	on timore	10d. Inside City Limits
Maryland 28a-f show 1 at once. ector			1 Yes 2 No
hours after death with the Maryland natural, or items 23a or 28a-f sho Examiner must be notified at once.	10e. Street and Number 9016 Deviation Road	10f. Zip Code 21236	USA
r death with or items 23 c must be no Funeral	1 Whover Married 2 Married Armed Forces? If You	s Decedent of Hispanic Origin? ( Specify Yes es, specify Cuban, Mexican, Puarto Rican, etc	or No- c.) 14. Race - American Indian, Black, White, etc.
after des al", or i	1 Ves 2A No	Yes 2 ^X No specify:	_{Specify:} White
2 hours "natur		t's Usual Occupation (Give kind of work done ost of working life. DO NOT use retired)	
5-0036 ed within 72 hours aft tygiene. Other than "natural" he Medical Examine Completed by		icher	Baltimore County
21215-0036 Juld be filed within 72 hours Mental Hygiene. marked other than "natur e event, the Medical Exami To Be Completed t	17. Father's Name (First, Middle, Last)  Raymond Hall	18.Mother's Name (First, Mi Kathryn S	
	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Douglas Hall/ Brother 2749	Address (Street and Number or Rural Rout Greene Lane Baldy	te Number, City or Town, State, Zip Code) win, MD 21013
4 5 5 5 5 5 T	20a. Method of Disposition  20b. Place of Disposition  1 X Burial 2 Cremation 3 Removal from State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State Garchem State G	ition (Name of cemetery, Date	20c. Location - City or Town, State  /09 Baltimore, MD
Baltimore, permit Pages I a Department of He Important: If ite	4 Donation 5 Other Specify:		
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Physician Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.  Immediate Cause (Final disease a. Smoke and soot inhal		ory arrest, shock, or heart Approximate Interval Between Onset and Death
`xaminer	Immediate Cause (Final disease or condition resulting in death)  a. SMOKE and Soot inhat  Due to (or as a consequence of):	ation	
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that the dated by the detached of Phy	Part II. Other significant conditions contributing to death but not resulting in the	and any mag according to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control	e. Did tobacco use contribute to the cause of death?
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tal Recidian: The certificate rector, page	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 FR/Outpatient	26.Place of Death (Check only one)	
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Division o  Spiral or Attending  Bours after death.  Bours Director: Aft  filled in by the fune  Certification:	3 Suicide 6 Could not be determined (Specify) residence	et, factory, office building, etc. 281. Loc or T Nott	ration (Street and Number or Rural Route Number, City Town, State) 9016 Deviation Rd ingham, MD
, 5 4 5 5 E	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner: On the basis of examination and/or investiga	rred at the time, data and place, and due to the	he cause(s) and manner as stated.
To the complet	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Patrice Wioni-Hollah -	O.C.M.E.	September 27, 2009
$-\psi$	30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD	21201
State Registra		/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 02:30 PM September, 22,2009 E FFREY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore 0 Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 10-19-1958 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) Days 1 ☐ M 2 ☐ F 50 220-72-4799 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1X Yes 2 □ No Baltimore Director Edgemere 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21219 USA 2406 Woodridge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify: <u>Ş</u> 3 Widowed 4 Divorced Completed 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Computer Field Engineer Sun Microsystems 1 and 2 should be filed wi Health and Mental Hygier em 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arlene Steinfort Earl Hudson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:3 Department of Health an Important: If Item 27 is any injury or other trau once. Karen Hudson - Wife 2406 Woodridge Road, Edgemere, MD 21219 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Normation 3 ☐ Removal from State Baltimore, MD Bayview Crematory 9-25-09 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licersee PA, 2134 Willow Spring Road, 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician absces weeks Due to (or as a cons ruence of): /Medical Examiner hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offi-Examine Hospital or Attending Physician: The law requires that the death certificate be executed Ed hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the principle of the terminal director, page 2 should be detached for use as the burial-transit Spinal Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 □Yes 2 ☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ⊟Yes 2 🖼 Ho 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Division of Vital Records, P.O. Box 68760, 24 hours a within 24 ho

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State

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

Halitha

HARITHA PENDLI

M.D; SINAI HOSPITAL OF 32. Peristrar's Signature anna

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D65718

29d. Date signed (Month, Day, Year)

BALTIMORE

September 22,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day September Physician Healer 2009 2356 Allison /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 27, 1985 Birthplace (State or Foreign
Country) 5. Social Security Number '. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F 220-21-4484 24 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10h County 10a. State 28a-f show artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 X No Director Columbia Maryland Howard 10g, Citizen of What Country? 10e. Street and Number 10f. Zin-Code Funeral 10617 Steamboat Landing 21044 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 Yes 2XXNo þ Specify: White 3 Wildowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Juid be inth and Mental H Be John William Healev Mary Ellen Newton ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John William Healey (Father) 10617 Steamboat Landing Columbia, Maryland 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page:
Department o
Important: If
any injury or
once. Altlantic Crematory 9-30-2009 4 Donation 5 Other (Specify) Glen Burnie, Maryland 21. Signature of Funeral Service Licenses Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 Approximate Interval Between Onset and Death Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final acute distress respiratory **Physician** disease or condition resulting in death) /Medical **Examiner** Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 - No 2 No 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA မ filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Division 1 Natural Injury 1 🗌 Yes 2 No 2 Accident after death Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated

To the within 2

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

100-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES 000

29d. Date signed (Month, Day, Year)

9-28-200

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 25, Year 2009 **Physician** SHIRLEY 9:35 РМ HOROWITZ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 16 BELLCLARE CIRCLE SPARKS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07-11-1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗙 F 87 MD 217-20-7012 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE **SPARKS** 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 16 BELLCLARE CIRCLE items 23a 21152 USA death v **Funeral**  Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 14. Race - American Indian, Black. White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 □ Never Married 2 □ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Yes, Give Specify: 2 3 Widowed 4 □ Divorced WHITE Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PIANIST MUSIC 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ISADORE** GERTRUDE LERNER ပ 19a. Informant's Name/Relationship (Type. Print)
ARLEEN SHEPHERD/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 BELLCLARE CIRCLE, SPARKS, MD 21152 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM. 09-29-2009 | REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 4 Denation 5 ☐ Other (Specify) 21. Signature of Funeral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Schamic 10NS **Physician** disease or conditio resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a very list conditions, if a very list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 ANo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NNo 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

24 hours a

within 2 To the I

4 Homicide

AARON

29b. Signature and title of certifier

29a. Certifier

Medical

32. Registrar's Signature 31. Date filed (Month, Day, Year)

ND

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

6701 N

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

harls

29d. Date signed (Month, Day, Year)

September 26 2009

09-07483

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Molly Hartman State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **Medical Examiner** MOLLY ERIN HARTMAN 0740 hrs September 25, 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8800 Margate Court Pikesville **Baltimore County** 5. Social Security Number 6. Sex If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Director Months Day: Hours Mir 220-83-1257 **0**2/27/2009 Country) 1 M 2 X F MD Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No or 28a-f show MD or items 23a or 28a-f show must be notified at once. BALTIMORE PIKESVILLE after death with the Maryland Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 MARGATE COURT 21208 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, or items 1 X Never Married 2 Married Armed Forces White, etc. 2 X No Yes 2 No specify WHITE tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner Widowed Divorced If Yes, Give Year Specify \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 leart of Health and Mental Hygiene. NONE NONE 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be DANIEL HARTMAN LESLIE KORFI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 MARGATE COURT, PIKESVILLE, MD 21208 DANIEL HARTMAN/FATHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 crematory or other place Removal from Stat Department o DHEB SHALOM MEM.PARK 09/27/2009 REISTERSTOWN,MD Other Specify 22. Name and Address of Facility SOL LEVINSON & BROS., signature of Funeral Service Lic. 8900 REISTERSTOWN ROAD. PIKESVILLE MD 21208 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interva failure. List only one cause on each line Between Onset and /Medical a.Complications of congenital disorder Immediate Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED 23a, 27, perME, g899 1/29/10 TT sician burial -XUNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: phy the b 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy use as Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) detached for 1 Yes 2 ✔ No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Yes 2 No 3 Probably 4 🗸 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? certificate ✓ Yes 2 1 🗸 Yes 2 No No 25. Was case referred to medical the Hospital or Attending Physician: 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 FR/Outpatient 3 DOA this ۵ 1 🗸 Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Director: Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be the Funeral D determined 4 Homicide 29a. Certifier 1 24 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 25, 2009

State Registra

Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Russell Alexander MD.

31. Date filed (Month

111 Penn Street, Baltimore, MD 21201

			State of Maryland /	Department of Health and M	1ental Hygie	ene	
			1 - State Registrar	Certificate of Death	Reg.	.No. 2 1 1 0 3 2 2	75
	Physic	ian	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year 3. Time of Dea	th
-	/Medi	cal	Kenneth W Jolley Jr.		09-3		М
	Exami	ner		4b. City, Town, or Location of Death		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Fo	
	Director		577609578 1MM 20F 63	Yrs. Months Days Hours Min.	(Month, Day, Ye	ear) Country) DC	reign
	P.		Usual Residence of Decedent		0 / 2		
	arylar show	-		wn or Location		10d. Inside City Li	
	he M	Director	Maryland Anne Arundel	Gambrills		1 □Yes 2 □	₩No
	with 1			10f. Zip Code	10g.	. Citizen of What Country?	
	Teath	Funeral	907 Autumn Valley Lane 11. Marital Status 12. Was Decedent Ever in U.S.	21054	ooify Voo or No	USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventrius the neithfield at once.			13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 □Yes 2 ☑ No Specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White	
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21	d wit	9	12	Painter		County Government	
nd	tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name			
yla	ould by Men	ည	Roy Jolley	Zora	Unknow		
Maryland	h and		19a. Informant's Name/Relationship (Type. Print)  Helen D. Jolley (spouse)	b. Mailing Address (Street and Number or Rura	al Route Number, Ci	ity or Town, State, Zip Code)	
a)	1 and Healt em 2			907 Autumn Valley Lane			
Baltimore,	Pages nent of l ant: If ite ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ery, crematory or other place)	01	: Location - City or Town, State	
Ħ	artme		4 □ Donation 5 □ Other (Specify) Glen 21. Signature (Funeral Service Licensels	Haven Cemetery 20		en Burnie, Marylar	
Ba	Depar Depar Impor any Ir		2 Sgriddie 1.1 urietar Ser W. S Ellu-insee	22. Name and Address of Facility 3	Stallings d Pasado	Funeral Home, P.A	4.
			23a. Part 1. Enter the disease, or complication that caused the death. Do shock, or heart failure. List only one couse of each line.				
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	sit ed	Examiner	Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying				
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	ificate g phys	edical	d				
Вох	death certiff e attending d for use as	2	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery	
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P.O.	at the de by the stached	چ	9 ☐ Unknown 9 ☐ Unknown		1		
<u>ග</u>	The law requires that the ate has been signed by the page 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?	?
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<u>۾</u>	has h	g l			24a. Was an autopsy	24b. Were autopsy findings availar prior to completion of cause	ible of
<u></u>	sician: The la certificate ha irector, page 2	- 1			performed		
Viita	Physician: r this certific ral director, I	Be -	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ matient 2 ☐ ER/Ou	26. Place of Death			N.
ō i	ding Phys h. After this funeral dii	۳. <del>ا</del>	The imparion 2 Live	apatient 3 DOA 4 Intersing Hom	ne 5 Residence 8d. Describe how in	6 Other (Specify)	
<u>o</u>	Attending It death. ector: After by the funer	atio	1 <b>□ Ma</b> tural 5 □ Pending (Month, Day, Year) II 2 □ Accident investigation	Time of 28c. Injury at 28 Work? 28 No 28 No 28 No 28 No 28 No 28 No 28 No 28 No 28 No 28 No 28 No 28 No 28 No	33. 2333123 11311 11	nary occurred	
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	ontal o				City or Town, St		
	Io the nospital of Atternation of Atternation of the To the Funeral Direct completely filled in by the	edical	29a. Certifier (Check only one)  1 → Certifying Physician: To the best of my knowledge 2 → Medical Examiner: On the basis of examination an and manner stated.	<ul> <li>death occurred at the time, date and place, and occurre indoor investigation, in my opinion, death occurre</li> </ul>	and due to the cause and at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)	
i i	To th Comp	Me	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)	
			) Silvin a	n DS1462	C	1/28/09.	
			30. Name and address of person who completed cause of death (Item 23a) (	,			
	Stat	0	31. Date filed (Month, Day, Year) 32. Registra's Signature	357 OXON HILL	LKd, C	DYONHILL M	0
	Registra	ır	31. Date filed (Month, Day, Year) 2009 32. Registrar's Signature	Sares	,	2079	15

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9 Month Day **Physician** Beatrice Jolly 7:45 a M 18 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frankford N/H N/A

9. Birthplace (State or Foreign Country) Baltimore 8. Date of Birth (Month, Day, Year) 4-27-1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Min. 1 □ M 2 X F Hours 214-72-5577 Director 82 S.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Show 7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Medical Examina in ust be notified at 1 Yes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3500 Brendan Avenue 21213 U SA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home llth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Porter Boyd ည Pauline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of item 27 is Sylvester O. Jolly-Son 3500 Brendan Avenue Balto, MD 21213 MD 21213 altimore, 20a. Method of Disposition

↑ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) o **=** Department of Important: If it any Injury or o Baltimore Cemetery 9-22-09 4 ☐ Donation 5 ☐ Other (Specify) Balto, Signature of Funeral Service Licensee March East F/H Brita Mila 21202 Balto, MD1101 E. North Avenue Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): ASW Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-tran Box 68760.8 resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) signed by the a Ö 1 ☐Yes 2 ☐ No 9 Unknown <u>a</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy certificate Division of Vital 1 ☐ Yes 1 ☐ Yes No Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes **2 12** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation spital or Attendi nours after death, neral Director: A death, 1 Tes 2 🗆 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Hospitai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5 completed cause of death (Item 23a) (Type, Print) 2/234 Waltham Woods 8813 31. Date filed (Month, Day, Year) Registrar's Signature State SEP 3 0 2009 Registrar

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	Disc. 1.1		1. Decedent's Name (First, Middle, La	ist)		-					2. Date of Dea Month	th Day	Year	3. Time of	Death
	Physici /Medio		Helen	Hall		Ki	ng				Septemb			9:50	A M
À	Examin		4a. Facility Name (If not institution, given	ve street and number	7)		4b. City,	Town, or	Location of	of Death		4c. Co	ounty of Death		
			Genesis Nursing					Plat		0415			arles		
	Funeral			Sex   7.A 1 □ M 2 🖾 F	ge (In yrs. la: 94	st birthday) Yrs.	If Under Months	Days Days	If Under Hours	Min.	8. Date of Birth (Month, Day 12-6-1	Year)	9. Birth	place (State o ntry) n Caro]	r Foreign
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	land W		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside Ci	ty Limits
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	28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Cou	ntry?	
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	death	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S	. 13.	Was Deced	ent of His	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		. Race - Amer		
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<u>.</u>	filed within 72 hours after death with the Maryland Hygiene. Ither than "naturel", or items 23e or 28e-f show ent, the Medical Examican must be inclined at	Completed	15. Decedent's E (Specify only highest gr			16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	tion uring mos	t of workin	ıg .	16b. Kind	of Business/Ir	ndustry	
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<u> </u>	should nd Me mark matfe	2	19a. Informant's Name/Relationship	Tvoe. Print)		19b. Mailir	na Address	(Street a	nd Numbe	er or Rura	Route Numbe	r. City or T	own. State. Zi	p Code)	
S	Ith ar 27 is r treu		Evelyn M. Prince				-				Waldor			_	
ē,	s 1 a f Hea item othe		20a. Method of Disposition			ce of Dispo	sition (Nam	e of	1	D	ate	20c. Loca	tion - City or T	own, State	-
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  By injury or other treumatic event, the Medical Examere must be radiited at once.		21. Signature Funeral Service Lice			22	2. Name and	d Address							
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	D #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseque	ence of):									
	ecute and trans	Examiner	that initiated events resulting in death) Last	C. Due to (or a	s a conseque	ann of):									
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<u>ta</u>	icien: Th certificate rector, pag	BeC	25. Was case referred to medical						26. Place	of Death	(Check only or	•	1 2 1 3 3		
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0	Attending Physicien: r death, ector: After this certifice by the funeral director,		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 2 ay Year)	8b. Time of Injury	28	Bc. Injury Work			8d. Describe h			-	
20	eath. or: A	cati	2 Accident investigation				М		′es 2 🔲 l	No					
Division of Vital Records,	or Attendate death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of Ir	njury - At hom ntc. <i>(Specify)</i>	ie, farm, str	eet, factory,	office		2	8f. Location (S City or Tow		Number or Rui	al Route Num	ber,
	pital ours a mel [	2	20- C-46 1 Mo-46 0							4.1	4.4		. •		
	To the Mospital or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate h completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medicel Exer	nysician: To the bes miner: On the basis and manner s	of examinatio	edge, death in and/or in	n occurred a vestigation,	in my op	e, date an inion, dea	d place, a th occurre	nd due to the c d at the time, c	ause(s) an late and pl	ace, and due	stated. to the cause(s	)
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	- s - ő		Allen Ax	8rla	n	W		1	120	160	4	Q	195	/ (X	/
1			30. Name and address of person who	completed cause of	death (Item 2	(Type	Pried			~	l		104	-7	
1	) V		George H: Wather					Sq.	#103	Wal	ldorf,	MD 20	603	1	^
	Sta	te	31. Date filed (Mor 3 DD). 33an 2		rar's Signatu		) -								
	Registr	ar		MAN CON	m p	1. 1	arked	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Oct 09 2036 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Balhmore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral Months Days Hours 1 ₩ 2 □ F 215-06-6471 1984 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Experiment must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 505 South Ponca Street 21224 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{No} \) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cook Food Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mark Joseph Kinslow Denise Lynn Esterline ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashley A. Kinslow - Wife 505 South Ponca Street, Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arundel 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Danation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. 9-29-2009 rematory 9-22. Name and Address of Facility Odenton, MD Signature of June of Serold Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato-shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death STRIPLING APPROPER ST. MEDICAL ELVINES Immediate Cause (Final disease or condition resulting in death) Physician Itana /Medical Due to ( s a cons quence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ cate has been signal, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 Pres 2 □ No 2 NO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifics completely filled in by the funeral director, F. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏ Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred P (Month, Day) 1900 5 Pending Year) 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, State) determined 4 Homicide Athime 17 Middle St MISCHA ENGLISHED. 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The pest of my knowledge, death occurred at the time, date and place, and due to the cadactor and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 19802 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1211186 umma Green St Balhmorie 22 31. Date filed (Month, Day, Year) 82. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 💹 🗓 📑 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 10PM **Physician** GLORIA MARY KYZOUR 200 28 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner da if Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Social Security Number Alge (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Year) Min 1 □ M ×2 🖵 F 84 Director 200-16-2791 1924 6, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f shot injury or other traumatic event, it is Natical Examine traumatic event, it is Natical Examine traumatic event, it is not in the Natical Examine traumatic event, it is not in the Natical Examine traumatic event, it is not in the Natical Examine traumatic event, it is not in the Natical Examine traumatic event, it is not in the Natical Examine traumatic event, it is not in the Natical Examine traumatic event, it is not in the Natical Examine traumatic event, it is not in the Natical Examine traumatic event, it is not in the Natical Examine traumatic event, it is not in the Natical Examine traumatic event, it is not in the Natical Examine traumatic event, it is not in the Natical Examine traumatic event, it is not in the Natical Examine traumatic event, it is not in the Natical Examine traumatic event, it is not in the Natical Examine traumatic event. 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5825 Comstrock Avenue 21206 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married じがい カソクロ Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify: White 3€Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 yrs. Southeastern Sales Co. Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Leo Lyons Anna Perry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 Is
any injury or other trau Mary Ellen Holt (Daughter) 603 Middlesex Rd. Baltimore, Md. 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 XXX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 10-2-2009 Baltimore, Md. 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 Signature of Funeral Service Licensee Detha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one c. us. on eac. line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tran Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE asn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) P.O. | the 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has b page 2 sl 24a. Was an autopsy performe certificate 1 □Yes 2 No Division of Vital 1 ☐ Yes 2 ☐ No or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation r death. I hours after death.

uneral Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 09.28.09 00000

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Malini

MD:

32. Registrar's Signature

9000 Franklin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** -28.200 Adolph Kleiner A. FRIEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Speri More Washington Medical Cental City Bus

5. Social Security Number 6. Sex 7. Age (In vis. last birthday) If Under 1 Year If Under 24 Hrs. BUZNIE 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours Days **¼**☐M 2□F 217-03-3989 Director August 8, 90 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Modical Examinar is ust be not lifted at 1 ☐ Yes 2 📉 No Director Maryland Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21108 USA Funeral 30 Linda Lane 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ¶Yes 2 If Yes, Give 2 No 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 ☐YNo 2 Specify: White 3X Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Quality Control Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be in Department of Health and Mental Important: If item 27 is marked o John Kleiner Elizabeth Schifferer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Linda Lane, Millersville, Maryland Beverly Foley Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 1. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 2009 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. MI Part 1. Enter the dise or complications that caused the deal Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failured ist only one cause on each line. Immediate Cause (Final **Physician** 2815 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Lines underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deat
4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 d Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? (es 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 14 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier Mi Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician** Clinton Walter Kersey, Jr. 19 2009 2:36A September /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day,
June 21, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 228-68-9901 60 Director Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 TxYes 2 □ No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 Argosy Drive United States 20878 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify þ White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Clergy Religion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Clinton Walter Kersey, Sr. Marion Carr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn S. Kersey/Wife 310 Argosy Drive, Gaithersburg, Maryland 20878 20b. Place of Disposition (Name of Commetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Important: If its
any injury or o
once. September 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipense M01498 Rockville, Maryland 20850 More and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction minutes /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □No 1∐Yes 2⊠No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 📆 No Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

30

DHMH 17 Rev 1/2001

State

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

Deborah J. Shervill,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's signatur

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

9901 Medical Center Drive, Rockville, Maryland 20850

29d. Date signed (Month. Dav. Year)

24 hours a within 2. 20

Baltimore, Maryland 21215-0036

Box 68760,0

P.0.

Division of Vital Records,

State Registrar

filled in by

Medical

TERRY JOORIE, MD, FACEP 31. Date filed (Month, Day, Year) SEP 3 0 2009

JOOR 16

30. Name and Idress of person who completed cause of death (Item 23a) (Type, Print)

4 Homicide

(Check only

29b. Signature and title of certific

29a. Certifier

one)



1 🖟 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D40324

29d. Date signed (Month, Day, Year)

THROMA

SEPTEMBER 28,2009

PARK, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 25,2009 **Physician** September 9:05 P M Hugh Kinsev /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Riverview Nursing Center Essex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) February 26,1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Min. 1**X** M 2 □ F Months Days Hours 330-08-1201 90 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2X No Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8228 Dundalk Avenue 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates Specify. Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Self Employed Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles S. Kinsey Alice J. Abshire ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2015 Emmorton Road, Suite 202, BelAir, Maryland 21015 Lawrence Demuth Attorney 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 30, 2009 Baltimore, Maryland St.Stanislaus Cemetery 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. ature of Funeral Service Licenses 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Pan 1. Enter the disease on complications that caused the death. on the enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each line. Immediate Cause (Final disease or condition resulting in death) 00 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 2. No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

Physician: The law requires that the death certificate be executed O. Box 68760, attending physician for use as the buna signed by the a d be detached for ۵. of Vital Records, page 2 s has certificate this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral To the Hospital or Attending

Director

28a-f show

7 is marked other than "natural", or Items 23a or 28a-f shor traumatic event, I'm Madoul Examinations to notified at

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Department of Health a Important: If item 27 is any injury or other traconce.

**Physician** 

Examiner

/Medical

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72 hours after

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. Pages 1 and 2 should be filk trrent of Health and Mental H tant: If item 27 is marked oth

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who come

00

29b. Signature and title of certifier



leted cause of death (Item 23a) (Type, Print)

09-07328 Ronald Lo

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ronald Lough		State of Maryland / Department of Health and Mental Hygiene  1-For State  Certificate of Death  Reg. No.										19 3128				
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Medical Examine		Ronald F	Raymond	l Lough				- City T-		nation of		Septembe	Day Year r 18, 2009		2055 hrs	
		4a. Facility Name (i Atlantic Ger			number)		4	b. City, Tov Berlin	wn, or Lo	ocation of	Death	Worcester				
Funeral		5. Social Security N	umber	6. Sex	7. Age	(In yrs. Ia	ast birthday)	If Under		If Under	_	8. Date of Bir	th(MM/DD/YYYY)	9. Birtl Foreigr		
Director		214-38-63	886	1 M 2 F	6	9	Yrs.	Months	Days	Hours	Min.	Jun. 2	29, 1940		untry) MD	
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212 ould b d Meni s mark	ᆰ	19a. Informant's Na	me/Relations	ship (Type, Print)			19b. Mailing	Address	(Street	and Numb	ber or Rur	al Route Nur	nber, City or Tow	n, State	, Zip Code)	
MD nd 2 sh alth an m 27 i	ı	Carolyn		Wife		Tan I	2802 Place of Disposi	Sarat	oga	Aver	nue,	Lansdo	wne, MD	212	227	
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Italic 17 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		20a Method of Dis Urial 2		n 3 Removal	from Sta	te Me	crematory or other adowrid Par	ner place)	mor	elery,						
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Ba perm Depa Imp	1		UMD	MON	MI	NO	27	19 Ha	mmor	nds E	rv R	d. La	neral H nsdown <u>e</u>	ome, Mo	21227	
Physician			Part I. Enter the disease, or complications that caused the death. Do'not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										art	Approximate Interval Between Onset and		
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** :00 AM 20: /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner mor 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day) **Funeral** 9/Birthplace (State or Foreign Days 1□ M 2 F Months Hours Min. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f sh Examiner must be notified 1 Yes 2 □ No Director more 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced "natural", 77 is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a, Informant's Name/Relationship (Type. Print) (S15 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: if item 27 any Injury or other tronce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 2009 3 Removal from State 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AUR B 23a. P. 11 Enter the in ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slight, or heart fillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INTARCTION CARDIA /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for set a consequence off Examiner Division or Vital Records, P.O. Box 68760 $ot \varnothing$ Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Dav 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 0006 1765

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

400 3350 WILLENS AVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

QUALDOO

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths, Last)   Coccounts Name (Pint Moths,														
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State 31. Date filed (Month, Day, rear) 32. registrars Signature.		6		30. Name and address of person who com		A COLOR	rint)	Anna	- /	14 7	100	25		
Registrar SEP 3 (1 2000)				31. Date filed (Month, Day, Year)	10			rne	CICAL	N, OK	105		-	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician **AGATHA** EFFIE LEMASTERS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MARINER HEALTH OF OVERLEA BALTIMORE 8. Date of Birth (Month, Day, Year)
FEB. 2,1919 WEST VIRGINIA If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🗙 F 218-16-3508 90 FEB. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examinar must be notified at 1 XYes 2 □ No Director N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 6101 CARDIFF AVENUE 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐Xlo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify: WHITE 3

Widowed 4 □ Divorced other than "natur 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSE MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 Is marked or r traumatic eve MILES LAMBERT 2 ELIZABETH CARR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT L. BISHOP/ SON 7005 5th AVENUE, DUNDALK, MD. 21222 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) BAYVIEW CREMATORY 10/2/09 BALTIMORE, MARYLAND 21. Signature of Fundal Strvice Licensee 22. Name and Address of Facility
LILLY & ZEILER INC FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Yea 5 Other (specify) ed by the a detached f 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No 3 Probably 4 Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 K No 1 ☐ Yes 1 ☐ Yes Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28h Time of After 28d. Describe how injury occurred 1 Natural 2/ Accident 5 Pending investigation death. spital or Attendi nours after death. neral Director: A filled in by the fu 1 🗆 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L Hospital Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aven Ochk 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			1 - State Of Ma. State Of Ma. Registrar	Cer	tificate of I		, 0	g. No. 🔬 🗓	US	31283	
	Physici		Decedent's Name (First, Middle, Last)     SOLOMON		LOVE		2. Date of Death Month SEPTEMBE	Day	Ye ar 2009	3. Time of Death 2:57 A M	
	/Medio Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		OLI TEMBE	4c. County		2.57 A	
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0000	aryland show	ř		10c. City, Town or Loc	cation				10	0d. Inside City Limits 1 X Yes 2 □ No	
	the M	ectc	MD N/A  10e. Street and Number	BALTIMORE	10f. Zip Code		10	g. Citizen of W	/hat Count		
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	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "refer Exact are rust be rotified at	d by Funeral Director	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🗐 No. If Yes, Give Year or Dates:	)	□Yes 2 No	Specify:	riiodii, cio.,	Specify:	k, White, e		
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פו	2 sho h and risum:		19a. Informant's Name/Relationship (Type. Print)			and Number or Run		•		·	
ָ ֖֖֖֓֞֝֝֝	1 and Health em 27 ther tr		ESTHER LOVE/WIFE  20a. Method of Disposition	/121 F	PARK HEIG	HTS AVEN	JE APT #	#101, B	ALT IN	10RE, MD 212	
	t. Page rtment c rtant: If rjury or		1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  ANSHE EMUNAH-AITZ CHAIM 09-27-2009 BALTIMORE, MD								
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	quires that n signed build be deta	þ	Part II. Other significant conditions contributing to death but	derlying cause give	en in Part I.	W			~		
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	lo the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral preserved.	Certification:	a ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	At home, farm, street, factory, office 28f.			f. Location (Street and Number or Rural Route Number, City or Town, State)			
		Medical C	29a. Certifier (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)								
:		Me	29b. Signature and title of certifier		29c. License	number	29	d. Date signed	(Month, L	Day, Year)	
			Meroning	0 68500			Sprente 25 2008				
,			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AARON J CHARLES M 670 N. Charlest Tonson M								
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar' SEP 3 () 2000	s Signature	Ried						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 5-45A M Κ. LEVITAN SEPT **ESTHER** 200 27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ENVOY OF PIKESVILLE PIKESVILLE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 □ M 2 1 F 98 Months Days 1177071910 MD 215-18-2131 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside Cify Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examples round be notified at Funeral Director N/A BALTIMORE 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7121 PARK HEIGHTS AVE., #504 21215 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2 X No Be Completed by Specify WHITE 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SIMON KESSLER ANNA SUGAR ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANET FEINBERG / DAUGHTER 7121 PARK HEIGHTS AVE., #504 BALTIMORE, MD 21215 permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of ANS Penetary) Place) 1 Burial 2 Cremation 3 Removal from State CHĀIM CONGREGATION 09/29/2009 BALTIMORE, MD 5 ☐ Other (Specify) Signature of 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Funeral Service Licenses 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 ame 23a. For 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death CARDIOVASCULAR Immediate Cause (Final disease or condition resulting in death) HTHEROSCLEROTIC DISEASE Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and pipetery filled in by the turnel director, page 2 should be detached for use as the burlan-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 4 Dunknown MPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed STED POROSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 □No 2 12 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 813 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature) and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number asheem 285 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTOMI) 2120 AVE, SUITE 233 AICHANI, MI 2875 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician SEPTEMBER 25, 8:11 P 2009 MCMAINES ELSIE /Medical 4c, County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. May 26, 1913 5. Social Security Number 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 1 XF Months Country) Marvland 96 Director 213-09-7013 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If them 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location other traumatic event, the Wedical Exacting rount by notified at 1 ☐ Yes 2√☐ No Directo BelAir Md. Harford 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21014 USA 706 Heston Court Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Armed Forces? I ∐Yes 2 XNo 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 1 ☐ Yes 2 🕅 No Specify. þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Christopher Filmore Harker မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 Heston Court Bel Air, Md. 21014 <u>Patricia E. Rink</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 9-29-2009 Parkville, Md. Parkwood 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Schimunek FuneralHome 21. Signature of Funeral Service Licensee 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Subarachrond disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** vertus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 Pregnant at time of death Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1º
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leral Director: #

filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 TAccident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 032721 Septimber 2 7. 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K DAVID DUNN 615 W MACPHAIL ROAD BEL AIR, MD. 21014

State

P.O.

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

SEP 3 0 2009

32. Registrar's Signature

			For State Registrar	State of	f Marylan		artmer <i>rtifica</i> i			and Me	ental Hy	giene Reg. No.	2005	- 100 - 100	129
	Physici	an	1. Decedent's Name (First, Middle, La	,							2. Date of De		Year_	3. Time	
-	/Medic		Donal		ughlin,	Jr.					eptemb		7, 2009	1:39	a. M
	Examin	ner	4a. Facility Name (If not institution, giv Suburban Hospita		nber)		Betl	nesda				Mo	County of Death		
	Funeral Director			Sex M 2□ F	7. Age (In yrs. 102	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under: Hours	Min. J	8. Date of Bir (Month, Da uly 26	th ay, Year) • 19	9. Birth Cour New	olace (State otry) York	or Foreign
	land Dw		Usual Residence of Decedent  10a. State 10b. County		10c, Cit	y, Town or Lo	cation						1	0d. Inside	City Limits
	Mary F sho	to	MD Montgome	ry	Gar	rett P	ark							<b>™</b> Ye	s 2∐No
	or 28g	<b>Funeral Director</b>	10e. Street and Number				10f. Zi					_	zen of What Coul	-	
	s 23a	rall	10706 Weymouth S				208						ed State		
•	ter de	Fune	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Dece Armed For 1 ☐ Yes	dent Ever in U. rces? 2 X1 No	S. 13.	Nas Dece f Yes, spe	dent of Hi cify Cuba	ispanic Ori in, Mexican	gin? (Spec , Puerto R	cify Yes or No lican, etc.)	)-	<ol> <li>Race - Americal Black, White,</li> </ol>		
15-0036	ral", o	β	3 X Widowed 4 □ Divorced	If Yes, Giv Year or Da	re .		1 □Yes	2 <b>X</b> No	Specify:				Specify: Whi	te	
<u>2</u>	72 hc "natur	etec	15. Decedent's E (Specify only highest gro	ducation ade completed)		16a. Deced	dent's Usu kind of wo	al Occupa	ation during most l)	of working	g		nd of Business/In hitectur		
7	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Middel Evar, incr. ust be notified at	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	Archi		se retired	"			Des		aı	
		Be C	17. Father's Name (First, Middle, Last		,						(First, Middle		Surname)		
yland	2 should be a and Mental is marked o raumatic eve	10 B	Donal McLaughlin						Jose	ephin	e Lack	er			
Mar	permit. Pages 1 and 2 should by Department of Health and Ments Important: If item 27 is marked any injury or other traumatic es once.	-	19a. Informant's Name/Relationship			1	_						r Town, State, Zij	Code)	
a) (a)	1 and Health em 27 ther t		Brian McLaughlin  20a. Method of Disposition	(son)	20h F						Park,		0912 cation - City or To	wn State	
aitimor	ages ent of nt: If it		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control		state	Place of Dispo emetery, cren sapeak				Sept 200	. 30,		tsville,		
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca one cause on ea	aused the deatl ach line.	n. Do not ent	er the mod	de of dyin	g, such as	cardiac or	respiratory a	rrest,		Approxima Interval B	etween
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. AC	UTE 1		ARDI	al I	INFAR	ectra	М			Onset and	Dealli
-	Examiner			Due to (	or as a consequ	uence of):									
		ner	Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Utie to (	or se a conesq	ience off:									
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c				_							
8/00,	be exician good	a E	resulting in death) Last	Due to (	or as a consequ	uence of):									
20	fficate physis the l	edical		d			-		-						
NO O	h certi ending use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			Je					2	23d. Date of deliv	ery	
ם .	e deat he attr ed for	sicia	in the past 12 months? 1 □Yes 2 □ No		oirth 2□Feta nant at time of d		Ectopic p Other (s		/				Month	Day	Year
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10 no	ding F	ion:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending		of Injury h, Day, Year)	28b. Time of Injury	M 2	28c. Injury Work			Bd. Describe	how injur	y occurred		
	Attend	ficat	2 Accident Investigation 3 Suicide 6 Could not b		of Injury - At ho	me, farm, stre			Yes 2⊡1		Bf. Location (	Street an	d Number or Run	a <i>l R</i> ou <i>te N</i> u	mber.
5	al or s s after al Dire	Certification:	4 ☐ Homicide determined	buildir	of Injury - At hong, etc. (Specify	y)		,			City or To	wn, State,	)		
:	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (	29a. Certifier 1	nysician: To the miner: On the ba and mann	asis of examina	wledge, death tion and/or in	occurred vestigation	at the tin	ne, date an pinion, dea	d place, a	nd due to the d at the time,	cause(s) date and	) and manner as : I place, and due t	stated. o the cause	e(s)
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	OV		30. Name and address of person who					۸۰۰۰	Vonce	inata	n MD	200	.05		
1	Sta	to	Barry N. Rosenba		• 3/20 egistrar's Signa	Farra	gut 1	ave.	rens.	riigco	II, FID.	200	30		
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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_			1 - State of Maryland / Department of Health and No.	-	Reg. No. 200	9 31292
	Physicia	an	1. Decedent's Name <i>(First, Middle, Last)</i> Muriel Ann Muller	2. Date of De Month	Day Year	3. Time of Death
	/Medic	al		Septembe		
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Sunrise of Columbia  Columbia		4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Bir		rthplace (State or Foreign
l,	Director		069-14-8884 1 □ M 2 🗷 F 88 Yrs. Months Days Hours Min.	8. Date of Bir (Month, Da July 7,	1921 N	ew York
	/land		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary Fred	tor	Maryland Howard Columbia			1 ∐Yes 21⁄2 No
	or 28	Directo	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	country?
	th wil	la [	6500 Freetown Road 21044		U.S.A.	
	r dea	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race · Am Black, Whi	
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, if a Medical Evandral must be redified at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 🖫 No If Yes, Give 1 □ Yes 2 🖾 No Specify: Year or Dates:		0	White
215-0036	2 hou	led	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business	
212	hin 77 e. an "n	ple	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  (Give kind of work done during most of work life. DO NOT use retired)	ing		
7	er tha	Completed	12 Homemaker		Own Hom	e
n D	be file	Be	T 1 T P	- (	, Maiden Surname)	
<u>\{ \} \</u>	ould Mer narke	ů		gatha Lug		
Maryland	d 2 sh th an t7 is r traur		19a. Informant's Name/Relationship (Type. Print)  Bruce Muller (Son)  19b. Mailing Address (Street and Number or Run 21260 Georgia Avenue Brook		er, city or rown, State, Maryland 2083:	·
<u>စ</u> ်	1 and Heal Heal tem 2		21200 SCOTAM THEME DESCRIPTION	Date Date	20c. Location - City of	
Ē	ages ent of nt: If ii		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Atlantic Crematory 9-28-	-2009	Glen Burnie,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examinating the notified at once.	104	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes,		Oldi Durine,	TEM YICHKI
<u>מ</u>	89 <b>5 29</b>	i ili	Multiple Soad 5555 Twin Knolls Road	Columbia	a, Maryland 2	1045
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a. Encephalopally.			Onset and Death
همد	/Medical Examiner		resulting in death)  Due to (or as a consequence off:			,
	D .≝	ner	Sequentially list conditions, if a ry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events conditions)			
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68760,	rtificate be executed ng physician and as the burial-transit		Due to (or as a consequence of):			
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XO	anding use a		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	elivery
ם מ	ed for	Physician//	in the past 12 months?  1 ☐ Yes 2 ✓ No  1 ☐ Helprogram 2 time of death 5 ☐ Other (specify)		Month	Day Year
T.	d by the	Phy	9 LI UNKNOWN	oo- Did	obacco use contribute	to the course of death?
ds,	ires the signer of the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the different the differe	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Custom e ous Diffuse Longe B-Cell Lyughama			Probably 4 Unknown
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VITAI H	in: Th		25. Was case referred to medical 26. Place of Deat	1 □ Yes	2 2 No 1 □ Ye	s 2□No
>	s cert lirect	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hospital:			Assisted
0	g Phy ter thi	Ë	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		how injury occurred	ecny, a. v. 18
VISION	endin sath. or: Af he fur	atio	2 Accident investigation M 1 □Yes 2 □No			
$\frac{8}{2}$	or Atter ter de irecto n by ti	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (. City or To	Street and Number or F wn, State)	Rural Route Number,
ַ	pital c		On Codification 1 Production Devices To the hold of the Code Code Code Code Code Code Code Cod			
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier  (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the red at the time,	date and place, and du	as stated. ue to the cause(s)
	To th Comp	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor	
			D0061624		9-25-0	9
	5 V	Ì	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Y. Louann 2hang, MD 10710 Charker Dr. Suite 6020	<i>(</i> )	1 10-	21214
	1		Y. Louann 2hang, MD 10710 Charker Dr. Suite 6020 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature.	Coli	umbia, MI)	21044
	Sta Registra		SEP 30 2009			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 3:08 A.M 27, 2009 September Margarete Therese Neteler /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Westminster Carroll Dove House 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1□M XXF Months Days Hours 75 217-60-2426 1934 Director July 10, Germany Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hyglene. m 27 Is marked other than "natural", or items 23a or 28a-f show her tranmatic event, the Medical Espaniac man to remind the control of the present of the standard of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of t 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State Funeral Director 1 ☐ Yes XX No Reisterstown Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 3422 Buttonwood Court 21136 America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □ Yes XIX No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Automotive Dealer Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willhelm Semrau Aenne Strohenke မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 I John M. Neteler (Husband) 3422 Buttonwood Court, Reisterstown, Maryland 21136 Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Coremation 3 Removal from State Sep. 29, 4 ☐ Donation 5 ☐ Other (Specify) 2009 Crematory Catonsville, Maryland 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21. Signature of Fune/al Service License Omar 3296 Charmil Drive, Manchester, Maryland 21102 Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RENAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy After this certificate has been signed by the atte funeral director, page 2 should be detached for i Month Day Year Pregnant at time of death 4 Pregnant 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🗖 No 2. No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 ROther (Specify Olic MO.) Hospital: 1∐Yes 2∏ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director; death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital within 24 hours

To the Funeral 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Q□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Cert Medi 29b le of certifier 29d. Date signed (Month, Day, Year) 29c. License number 9/20/05 dress of person who completed cause of death (Item 23a) (Type, Print) 555

Registrar

31. Date filed (Month, Day, Year)

**SEP 30** 

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records.

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 23, 2009 **Physician** 1:36 P M Catherine ٧. Nicholson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Lorien Mt. Airy Mt. Airy 8. Date of Birth (Month, Day, Y. March 9, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** , 1923 Maryland Months Days Hours Min. 579-18-4451 1 □ M 2 🕅 F 86 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Director the Medical Examiner must be notified Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13416 Accent Way 20874 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White 2 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Burton Duley Mary Alberta Whalen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any Injury or other trau
once. Bonnie Cope / Daughter 13416 Accent Way, Germantown, Maryland 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 28, 2009 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee Inglotte Brown 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Week Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure-Acute **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Chronic Obstructive Pulmonary Disease Years Physician/Medical Examiner Due to (or as a consequence of) 1. Box 68760, 81. or Attending Physician: The law requires that the death certificate be executed burial-trans Years Diabetes that initiated events resulting in death) Last Due to (or as a consequence of): Hypertension Years IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Advanced Peripheral Vascular Disease, Basal and 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Squamous Cell Carcinoma, Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1∐Yes 2XINo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Medical 29a. Certifier 1 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R115203 September 23, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara A. Spencer, CRNP Evercare 6095 Marshalee Drive, Elkridge, Maryland 21075 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 3 0 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #31 per DVR 8895 9730/09 II.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician**  $\mathbf{P}^{\!\mathsf{M}}$ Nicol1 September 27,2009 7:20 Mary Leona /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Harford Upper Chesapeake Medical Center 8. Date of Birth (Month, Day, Year) August 2,1918 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1□ M 2□ F 213-05-2164 91 Yrs MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d Inside City Limits 10a. State 10h. County 10c. City. Town or Location ral", or items 23a or 28a-f shov Exeminer must be notified at 1 □Yes 2 No Director Fallston Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21047 1819 Abelia Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White "natural", or 1 ☐ Yes 2X No Specify: Specify: 3 ₩ Widowed 4 □ Divorced er than "natur 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Dept Store is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Robert L. Jackson Margaret E. Metzger ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i Diane Cook- Daughter Fallston, MD 21047 1819 Abelia Rd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 10/1/09 Elkridge, MD 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc Signature of Funeral Service Licensee 6415 Belair Rd Baltimore, MD 21206 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart. — e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is a sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): led by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ∐Yes 2. No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has After this certificate 1 □ Yes & No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physiclan: T 24 hours after death. Funeral Director: After this certifical To the within 2

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year State Registrar

cai

29a, Certifier (Check only one)

29b. Signature and title of certifier

Simon Scalia 32. Registrar's Signature

and manner stated.

2801 Hudson Street

24276

29d. Date signed (Month, Day, Year) a. 58.91

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

21224 Baltimore MD

Sever S. parked SEP 3 0 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Month 0310 AM NATHAN NUSINOV September 24 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Sinai HUSDI tal Baltimore 01 6. Sex 1 M 2 F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Days 89 04/03/1920 216-32-8150 **Director** RUSSIA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "walted Expendent must be not filled at 1 ☐ Yes 2 No Director BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3221 PATMOR ROAD 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No ARMY If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🔀 Married 21215-0036 1 □Yes 2 No WHITE ģ 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWNER **JEWELRY** Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NUSINOV EDITH LENT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3221 PATMOR ROAD, OWINGS MILLS, MD ROSE NUSINOV / WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State OHEB SHALOM MEMORIAL 09/27/2009 REISTERSTOWN, MD 21. Signature of Funery Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 ome 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only on ations that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each li Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to ( r as a consequence of): Examiner Atherosclaratic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician a for use as the burial-Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital within 24 hours a McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)
SEP 30 2009

32/Registrar's Sign

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Melene

32/Registrar's Signature

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SINAI HOSPITTAL OF

September 24,2009

BALTUMORE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Walter Nowicki 28,2009 September 12:30 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 7503 Chesapeake Avenue Edgemere If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Months **1**X M 2 □ F 86 214-16-5535 Director October 1, 1922 Maryland Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the trade Even in the most 1 ☐ Yes 2 📆 No Director Baltimore Edgemere Maryland the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21219 USA 7503 Chesapeake Avenue permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the "Medical Exercises 2008. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Self Employed Tavern Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Feliks John Nowicki Ewa Wisniewska ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Nowicki wife 7503 Chesapeake Avenue, Edgemere, Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 1. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland ^{22. Name and Address of Facility} Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21. Signature of Funeral Service Licensee 21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bladder Cancer **Physician** MLZ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4 Pregnant at time of death 5 Other (specify) P.O. ned by the 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à Wellitus icate has been si page 2 should b 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 039660 September 28, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ha (timore Robert Dart 32. Registrar's Signature Rd ale 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 Constant.

		for State Registrar	•	artment of Health and rtificate of Death		ene 1. No 11 FLC - 3 L D (1. D)
		Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
Physic		Walter W. Pleines,Jr.			Septemb	Day 27 Year 330 pm
/Medi Exami		4a. Facility Name (If not institution, give street and n	umber)	4b. City, Town, or Location of Deat		4c. County of Death
		Northwest Hospital		Randallsto	own	Balto.
Funeral	Г	Social Security Number     6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs	8. Date of Birth	
Director		219-26-7536 ¹ X № 2□ F	71 Yrs.	Months Days Hours Min.	December	2,1937 Maryland
pu >		Usual Residence of Decedent  10a. State 10b. County	10- 0:t- T			Lod Inside Oits Limite
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with a or	قَ	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Country?
eath	era	9438 Bellhall Drive 11. Marital Status 12. Was De	cedent Ever in U.S. 13. V	21236 Was Decedent of Hispanic Origin? (S	Specify Ves or No-	USA  14. Race - American Indian,
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Ther than "natural", or items 23a or 28a-f show ont, tra. Wadfeal Evaniner must be notified at	Funeral	Armed F	Forces?	f Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, etc.
21215-0036 d within 72 hours aft giene. or than "natural", or	þ	3 ☐ Widowed 4 ☐ Divorced Year or	Rive 1959-1961	I∐Yes 27∏ No <i>Specify:</i>		Specify: White
5-0	Completed	15. Decedent's Education (Specify only highest grade completed	16a. Deced	dent's Usual Occupation	rking 16	6b. Kind of Business/Industry
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be fill that H and out out	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, Ma	
laryland 2. Should be filed w and Mental Hygie is marked other t	မ	Walter Pleines, Sr.			n Ann Bake	
Mal 12 st th and 7 is n traun	1	19a. Informant's Name/Relationship (Type. Print) Noreen Pleines	1	g Address <i>(Street and Number or R</i> 38 Bellhall Drive		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, traumatic and once. any once.		20a. Method of Disposition				Oc. Location - City or Town, State
ages int of t: If it		1 🖫 Burial 2 🗆 Cremation 3 🗆 Removal from	n State	sition (Name of natory or other place)	1	•
Itin		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fund Service Licenses	Holly Hi	LIS   10-3 Name and Address of Facility		Middle River, Md.
Bal permi Depar Impor any ir		21. Signature of Funda Service Little	22	9705 Belair		Funeral Home ingham, Md. 21236
		23a. Part 1. Enter the disease, or complications that	caused the death. Do not enter			t Approximate
Dhysisian	2.	shock, or heart failure. List only one cause on Immediate Cause (Final	each line.	u o em e me		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	STAGE LUA o (or as a consequence of):	16 CANCEL		
Examiner		Due ii	MESOTIFELL	201 A		
	ē	Sequentially list conditions, b.	. (Ur as a consequence of):	U/ V (/ X		
ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  C				
O, e exe ian ar irial-ti	EX	resulting in death) Last Due to	(or as a consequence of):		-	
I Records, P.O. Box 68760, A. The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical	d				
c 62 ertific ling p	Mec	IF FEMALE:				1
Box 61 leath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delivery  Month Day Year
P.O. I	/sic	1		Other (specify)		mental Buy rous
that the ed by		Part II. Other significant conditions contributing to	death but not resulting in the un	derlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
Records, P ne law requires that s has been signed t ge 2 should be dete	d by		3	, , , , , , , , , , , , , , , , , , , ,		2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Cord w requir	Completed			-		·
The law cate has page 2 s	m d				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
	ပ္ပ	25. Was case referred to medical			1 □ Yes 2	No 1 □Yes 2 ☑No
	o Be	examiner?	Inpatient 2 ER/Outpatien		ath (Check only one)	ce 6 Nother (Specify)
Of B Phy er this eral d	IE 4	27. Manner of Death 28a. Date	e of Injury 28b. Time of	28c. Injury at	28d. Describe how	
e fun	ațio	1 ☑ Natural 5 ☐ Pending (Mo 2 ☐ Accident investigation	nth, Day, Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
Division of all or Attending Physical for Attending Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physical Physi	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Plac	e of Injury - At home, farm, stre ding, etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Stre	et and Number or Rural Route Number,
Divagnation State	Certification:	4 - Horneide Built	dirig, etc. ( <i>Specify</i> )		City or Town,	State)
DIV To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by		29a. Certifier  (Check only  2 Medical Examiner: On the	ne best of my knowledge, death	occurred at the time, date and plac	e, and due to the cau	use(s) and manner as stated. e and place, and due to the cause(s)
the H nin 24 the F	Medical	and ma	nner stated.			e and place, and due to the cause(s)
To with	2	29b. Signature and title of certifier	Rea ton	29c. License number	290	I. Date signed (Month, Day, Year)
, \		I her necessale & 1	uner!	H4573/	S	ptember 27 2009
1241		30. Name and address of person who completed car	use of death (Item 23a) (Type, F	Print)	AA A - & Copper	M/ M/M
1"		Deborah Burt 31. Date filed (Month Par Year)	Begistrar's Signature	Print) DOGNET ROAD PA	NIVICYON	//V MD
Sta Regista		SEP 3 0 2009				

			State of Maryland / Depar Print in Black index  1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar Certification    1- State Registrar		lental Hygie	_	31299
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month September		3. Time of Death
	/Medic	al	Dorothy Parizek  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	September	4c. County of Death	12:25P M
	Examin	er	Riverview Nursing Home	Essex		Balto.	
	Funeral Director		218-18-9130 1 M 2 AF 85 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y February	9. Birthp 24,1924 M	lace (State or Foreign stry) ary1and
	Maryland f show ied ut	tor	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Loca   Md.   Balto.   Pe	erry Hall		1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	n 28a-	irect	Md. Balto. Pe	10f. Zip Code	10g	. Citizen of What Cour	itry?
	ath wit	ralD	4919 Berry Hill Circle	21128		USA	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 le marked other then "naturel", or Items 23a or 28a-f show enty injury or other traumatic event, I'm Madical Exam and Item of Item 1 and 100.0.	by Funeral Director	1 Never Married 2 Married 1 Yes 2 X No	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
Maryland 21215-0036	nin 72 hor n "nature Wedical E	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kii life. DC	nt's Usual Occupation nd of work done during most of work O NOT use retired)		b. Kind of Business/Ind	
7	ed with ygiene yer the t, the		10th Key	Punch Operator		ate of Mar	yland
yland	ould be fil Mental H arked oth	To Be	17. Father's Name (First, Middle, Last) Unknown Colbert	Fann	ie Unkno		
Mar	nd 2 should lith and 27 le m		19a. Informant's Name/Relationship (Type, Print)   19b. Mailing   Kevin Parizek   Son   1907 I	Address (Street and Number or Run Longview Avenue	a <i>l R</i> oute Number, 0 Rosedale <u>:</u>	City or Town, State, Zip, $\mathrm{Md} \cdot 21237$	Code)
nore,	ages 1 ar nt of Hea t: If item: 7 or other		20a. Method of Disposition  17 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	atory or other place)		c. Location - City or To	
Baltimore,	permit. P Departme Importen eny injur.		, and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second		chimunek	Funeral Ho	me
68760, 0,	Cate be executed hysician and hysician and hysician and the burial-transit	dicai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ic Cornery F	0 12	reare	Interval Between Onset and Feath
P.O. Box 6	To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medi		ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
Ś	w requires that s been signed b should be deta	d by Pl	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I.		cco use contribute to the	he cause of death? pably 4 🖽 nknown
Division of Vital Record	The law rec ate has bee page 2 shou	Complete	Skind Stenais, S Choic Molnutriti-	Servere Arenic	• 24a. Was an autopsy performe	24b. Were auto prior to co death? 1 \( \subseteq Yes	psy findings available mpletion of cause of
Vita	sician: certific rector.	Be	25. Was case referred to medical examiner?  1   Yes   2   No	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	h (Check only one)	- 500	
J of	g Physter this	in; To		28c, Injury at Work?	28d. Describe how	ce 6 Other (Specification occurred)	7)
ivision	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury · At home, farm, stree building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
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<b>.</b>	To the within 2 To the complete	Med	and marrier states.	29c. License number  D - 38-75	4 6	1. Date signed (Month,	Day, Year) 2009
7	5		29b. Signature and differ M.D  30. Name and address of person who completed cause of death (Item 23a) (Type, Pr. MALIFA WASEEM. FOSI. J.	PASTERN Q	3 LVD.	M.D-2	1221.
<b>.</b>	Sta Registr		31. Date filed (Month, Day, Year) SEP 3 0 2009  32. Registrar's Sanature				

			For State	State o	f Maryla	nd / Depa	artment o tificate o				- /	onne	01000
	Physicia	m/	Registrar  1. Decedent's Name (First, Middle)			007	incate	, Dea		2. Date of Dea			3. Time of Death
	Physicia Medic	al	Kathleen F.  4a. Facility Name (if not institution	Price	herl		4h City Toy	n or loo	ation of Death	Septembe			1:58 P _м
	Examin		Gilchrist Center		501)		Towsor		ation of Death		^{4c.} B	ounty of Death	
	Funeral Director		5. Social Security Number 212 48 3395	6. Sex 1  M 2  F	7. Age (In yrs. <b>62</b>	. last birthday) Yrs.	If Under 1 \ Months D		Under 24 Hrs. ours Min.	8. Date of Birt (Month. Day October	h 13°194	9. Birth 16 Balti	nplace (State or Foreign More , Maryland
	nd <b>how</b> at	'n	Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Loc	ation						10d. Inside City Limits
	Maryla 28a-f s otified	irect	Maryland Baltimo	re	Bal	timore Co	ounty						1 🗆 Yes 2 💆 No
	with the 23a or ist be n	Funeral Director	10e. Street and Number 6015 Point Pleasar	nt Road			10f. Zip Co 21206	de			10g. Citize USA	en of What Cou	untry?
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Fun	11. Marital Status  1  Never Married 2 Maria 3 Widowed 4 Divorced	If You City	ces? 2 XXNo	1	Yes, specify	Cuban, Me No Sp		cify Yes or No- Rican, etc.)	Sp		, etc. ite
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12 p	lled with Hygier other t rent, th	Be	17. Father's Name (First, Middle,			Secreta	iry	18.	Mother's Name	e (First, Middle,	,		cial Corp.
ylan	uld be fi I Menta narked natic ev	욘	Andrew Morrow							Faustil			
, Ma	id 2 sho salth and n 27 is r er traun		19a. Informant's Name/Relations William S Price	(Husband)		19b. Mailin 6015 P	g Address (St <b>Point Pl</b>	reet and N <b>Pasant</b>	lumber or Rura Road	Route Number Baltimor	r, City or To e ,Mary	own, State, Zip 1 <b>.and 212</b>	Code) 2 <mark>06</mark>
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other tonce.		20a. Method of Disposition  1) A Burial 2 Cremation 4 Donation 5 Cother (	3 ☐ Removal from Specify)	State _	Place of Dispos cemetery, crem rkwood Ce	natory or other	f place) 9/30	1	Date		ation - City or 1	
Balt	permit. Departi Import any inj		21. Signature of Funeral Service	Licensee		22	Name and A	dress of Unera	Facility 1 Home In	nc nore.Mary	Jond 3	21226	
	Pnysician/ Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Causes (Final disease or condition resulting in death)	r complications that connections on each	aused the deach line.  or as a con led	cana	r the mode of						Approximate Interval Between Onset and Death
٥ ٤٠	be executed sician and burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	с	or as a consec							-1	
O. Box 68/60	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Birth 2 ☐ Fe nant at time of	tal death 3	Ectopic preg				23	3d. Date of deli Month	very Day Year
S, P.C	ires that signed t d be det	by	Part II. Other significant condition	ons contributing to de	eath but not re	esulting in the u	nderlying caus	e given in	Part I.	23e. Did to			the cause of death?
records,	The law requate has been bage 2 shoul	Completed								24a. Was a autop perfor	rmed?	prior to co death?	opsy findings available ompletion of cause of
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N OT V	iding Phys th. After this funeral di	cate: To	27. Manner of Death  1 Natural 5 Pendin 2 Accident Investi	28a. Date of (Montil		ER/Outpatien 28b. Time of injury	28c.	njury at work? 1 ☐ Yes	2	me 5 🗆 Resid			n nospue
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	he Hospit in 24 hour he Funera ipleted fille	Medical	(Check /2 L Medical E	Physician: To the be Examiner: On the basi Nurse Practioner: T	s of examination	on and/or investi	gation, in my o	pinion, de	ath occurred at	the time, date as	nd place, ai	nd due to the ca	ause(s) and manner stated.
D	To t To t		29b. Signature and title of certifie	ulm	7		29c, <del>Lic</del>	ense num	2830	3		signed (Month,	Day, Year) 26 2009
	15		30. Name and address of person	who completed cause	. /	m 23a) (Type, P	rint)	arh	× S1	- 70	~ 55 m	JMO	
	Stat Registra		31. Date filed (Month, Der, Year) SEP 3 0 2	32. Re	egistrar's Sign	ture	led .		<u>. ب</u>				

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Physicia	ın	1 - State Registrar  1. Decedent's Name (First, Middle Suseela Per			Ce	rtificate of i	Death	2. Date of De	eath nber ^{Day} 27,	2009	3. Time of Death 3:00 P M
/Medic	al	4a. Facility Name (If not institution	n, give street end number)			4b. City, Town, or				ty of Deat	
		Montgomery Hos					ville			ntgon	
Funeral Director		5. Social Security Number 215–80–9504 Usual Residence of Decedent	6. Sex 7. Ag 1 ☐ M 2 ☑ F	67	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		2, 1942	9. Birti Co Inc	hplace (State or Foreign untry) dia
ryfand ihow	_	10a. State 10b. County		10c. City	, Town or Lo						10d. Inside City Limits
he Ma 28a-f s	ecto		gomery			Rockvil	.1e		10g. Citizen o	f Mile at Ca	1⊠Yes 2□No
aa or 3	Funeral Director	10e. Street and Number 1808 Yale Place	ce			10f. Zip Code	850		Unite		-
death	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin?	(Specify Yes or No	D- 14. R	ace - Ame	rican Indian,
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If term Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	ğ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced				1 □Yes 2 No	Specify:	sito riican, etc.)	Spec	ity: Asi	Lan
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ages 1 and of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation		20b. P Mor	lace of Disponentery, crea	osition (Name of matory or other place ry ium, Inc.	oe) Oc	tober 1,	20c. Location Beth		Town, State Maryland
ermit. Pa Departme Inportant In Injury		4 □ Donation 5 □ Other (S			2	2. Name and Addre	ss of Facility R	obert A.	Pumphr c. 7557	ey Fu Wisc	ineral Home/ consin Avenue
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Physician /Medical Examiner	L	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. End St  Due to (or as	age R	uence of):	Disease					Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C Due to (or as				*****				
the death certifi y the attending I iched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3	□ Ectopic pregnanc □ Other (specify) _	Sy		1	Date of de	livery Day Year
ires that signed b	by	Part II. Other significant condition  Vertebral Comp				underlying cause giv	en in Part I.				the cause of death?
The law requate has been age 2 shoul	Completed	Diabetes Mell:	itus					24a. Was auto perfe	opsy ormed?		utopsy findings available completion of cause of
cian: ertifica	Be C	25. Was case referred to medica examiner?						eath (Check only	1		
Physic this c	၉	1  Yes 2 No 27. Manner of Death			ER/Outpatie	ent 3 DOA Oth	4 🗆 Nursing	Home 5 ☐ Res		ther (Spe	oice Inpatien
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3		30. Name and address of person Jocelyne Touke	· ·				ty Park	way, Balt	timore,	MD 2	1218
Sta Registr	- 1	31. Date filed (Month, Day, Year)	9 Several	rar's Signa		w.	-				
HMH 17 Rev 1/2		APPL O CO	N person	10.11	A CONTRACTOR OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF TH						

			State of Maryland / Departn  1 - State Registrar Certific	nent of Health and N cate of Death		ene . No. 2009	31302
			Decedent's Name (First, Middle, Last)		2. Date of Death	400 400 400	3. Time of Death
	Physicia /Medic		Louis Rebuck ,Jr.		Month September	27,2009	2:00P M
	Examin			City, Town, or Location of Death		4c. County of Death	1
			9002 Tammy Road	Nottingham		Balti _r	nore
	Funeral Director			Under 1 Year   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.   If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye November	9. Birth Cou 19,1955 M	place (State or Foreign intry) aryland
	pu. »		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	laryla shor	ō	Md. Baltimore Notti				1 □ Yes 2 No
	the N 28a-1 28a-1	rect		Of. Zip Code	100	. Citizen of What Cou	
	with 3a or		9002 Tammy Road	21236	1.09	USA	,
	ms 2;	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D	Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	ican Indian,
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Madical Examiner must be notified at once.	by Funeral Director	Armed Forces? If Yes 1 [XNever Married 2 ☐ Married 1 ☐ Yes 2 [X]No	, specify Cuban, Mexican, Puerto es 2 <b>∑</b> No <i>Specify:</i>	Rican, etc.)	Black, White Specify: Wh	
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<u>8</u>	Men Men arke atic	10	Louis C.Rebuck, Sr.	Delores	Scardina	1	
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ב ב	of He		20a. Method of Disposition  20b. Place of Disposition  cemetery, crematory	(Name of y or other place)	Date 20d	c. Location - City or T	own, State
a 1 1 1 2	Page ment ant: If ury o		1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) st. Stanis1		·2009 Ba	altimore,	Md.
מ	permit. Departr Imports any Inj		21. Signature of Funeral Service Licensee	me and Address of Facility Sc 9705 Belair Rd			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the			· · · · · · · · · · · · · · · · · · ·	Approximate
	Physician /Medical	0 0	Immediate Cause (Final disease or condition resulting in death)  A condition a. a. a.	4	1 "		Interval Between
	Examiner		Due to (or as a consequence of):				
٨.	sit ed	Examiner	Sequentially list conditions, if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of).				
10	icate be executed physician and the burial-transit	хап	resulting in death) Last  C				
5	sician buria	alE					
		edical	d			'	
5	eath certifi attending for use as	Ž.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	very
5	at the death by the attertached for	Physician/M	in the past 12 months?	opic pregnancy er (specify)		Month	Day Year
	res that isigned by be detailed		Part II. Other significant conditions contributing to death but not resulting in the underly	ring cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
2	quires an sigi uld be	ed by			1 □ Yes	2 □ No 3 □ Pro	obabły 4 Unknown
2	e faw requir has been s e 2 should	plet			24a. Was an		opsy findings available
	ate ha	Completed			autopsy performed 1 □Yes 2	d? death?	ompletion of cause of 2 □ No
2	sician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	1	h (Check only one)		
5	Physical this cal dire	6	1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 27. Manner of Death 28a. Date of Injury 28b. Time of			e 6 ☐ Other (Spec	eify)
5	ending Ph sath. or: After th he funeral	ation	TS Natural 5 □ Pending (Month, Ďay, Year) Injury 2 □ Accident investigation M	Work?	28d. Describe how	injury occurred	
	al or Att s after de il Direct ed in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
;	To the Hospital or Attending Physician: The law requires that the death certiful 24 hours after death certiful 24 hours after death set in 24 hours after death after this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur (Check only one) 2 Medical Examiner: On the basis of examination and/or investigant manner stated.				
	To th To th comp	Me	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month	Day, Year)
	,		Filmen Jackel	136814		41281	ery
	5		30. Name and address of person who completed cause of deal (Item 23a) (Type, Print)  Process CLAOSUG 1525 05 UV	DR. Suine 3	3-70	owen p	10 21204
	Stat Registra	_	31. Date filed (Month, Day, Year) 32. Registrar's Schature				

DHMH 17 Rev 1/2001

09-07572 Mary Reardon Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death Decedent's Name (First, Middle, Last) Physician/ Month Day Y September 28, 2009 1600 hrs Mary Doreen Reardon Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Randallstown Seasons Hospice at Northwest Hospital Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Country) Hours Months Davs Director Yrs 1 M 2 X F New York 125-34-3080 66 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No 23a or 28a-f show notified at once. Gwynn Oak Balto. Md. death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 7136 Fairbrook Road 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces' 1 Never Married 2 X Married Yes 2 X No Specify: White Yes 2 X No specify: f Yes Give Year Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed or other traumatic event, the Medical Exa mit. Pages 1 and 2 should be filed within 72 ho artment of Health and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Home 12 Homemaker 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Thomas Conlon Catherine Morrissey Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 7136 Fairbrook Road Gwynn Oak, Md. 21207 John H. Reardon, Sr. Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 10-4-2009 Gwynn Oak, Md. Woodlawn Donation 5 Other Specify: Schimunek Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Pervice Licen-9705 Belair Rd. Nottingham, Md. 21236 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on each line Death Micdida Complications of erroneous insulin injection Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Diabetes mellitus Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical ttending physician a r use as the burial -X UNPENDED AMENDED line a-b, PII, 27,28a-f,perME, g897 PΙ 11/6/09 P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 V No 9 Unknown certificate has been signed by the att ector, page 2 should be detached for g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions ò 1 Yes 2 V No 3 Probably 4 Unknown Hypertension, obesity Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed' 1 🗸 Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) After this certific funeral director, I 25. Was case referred to medical the Hospital or Attending Physician: hin 24 hours after death. Division of Vital Be Other₄ examiner? Hospital: 1 / Inpatient 2 DOA Nursing Home 5 Residence ER/Outpatient 3 No 2 1 ✓ Yes 28c. Injury at Work? 28d Describe how injury occurred subject injected incorrect 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Manner of Death Certification: Yes 2X No 1 Natural Pending 9/13/09 insulin To the Funeral Director: completely filled in by the 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 136 Fairbrook Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined Baltimore, (Specify) home Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 29, 2009 O.C.M.E. and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 31. Date filed (Month, Day, Year) SEP 3 0 2009 32. Registrar's Signature State

Registrar

09-07559 Sadie Ricks Physician/ Medical Examiner **Funeral** Director f show filed within 72 hours after death with the Maryland Director Funeral <u>2</u> Completed is marked other than atic event, the Medical 21215-0036 Hygiene. Tealth and Mental I and 2 should be ٩ Baltimore, MD If item 27 **Physician** /Medical raminer Examine and Physician/Medical tending physician a lor detached ð Completed certificate has page 2 s Be this

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Y September 28, 2009 0932 hrs Sadie Ricks 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 701 Arlington Avenue Apt. 704 Baltimore 5. Social Security Number If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign North If Under 1 Year 7. Age (In yrs. last birthday) Months Days Hours Country Carolina 218-34-1289 3, 1927 1 M XXF 82 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location XX Yes 2 No MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 701 Arlington Ave. Apt. 704 21217 U.S.A. 13. Was Decedent of Hispanic Ongin? ( Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' XX Never Married 2 Married XX No Yes B1ack Yes, Give Yea Specify Widowed Divorced Yes XX No specify. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Domestic Housekeeping 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas Moore / Friend 405 Greenspring Valley Rd. Owings Mills, MD 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition St. Lukes Church 1XX Burial 2 Cremation 3 Removal from State 10/02/09 Reisterstown, MD Donation 5 Other Specif Cemetery 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licer 11605 Reisterstown Rd. Owings Mi**11**s,MD2111<mark></mark>7 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and failure. List only one cause on each line Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 V No 3 Probably 4 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 ✔ No funeral director, 25. Was case referred to medica 26.Place of Death (Check only one) examiner? Other-Hospital: 1 Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 V Yes After 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey, Year) 28b. Time of Injury Certification: 1 V Natural Yes 2 No death. Pending the Director: 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City within 24 hours after 3 Could not be Suicide or Town, State) determined To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 29, 2009 O.C.M.E. - Imn 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001

State Registrar

Donna M. Vincenti, MD

OCME

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

		-	For State Registrar	State of Man			it of Hea e of De			giene Reg. No.		
	Physicia	an	Decedent's Name (First, Middle, Las Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand Grand G		M. Rei	d			2. Date of Dea Month Septemb		, 2 ^{Year} 9	3. Time of Death 12:30 PM
	/Medic Examin		4a. Facility Name (If not institution, give Suburban Hospita	street and number)		4b. City,	Town, or Lo	cation of Death		4c. C	ounty of Death	ry
į,	Funeral Director	24	5. Social Security Number 6. S		n yrs. last birthda Yrs.	y) If Under Months	r 1 Year If	Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day February	v Year)	Couit	place (State or Foreign ntry) gium
	land w t		Usual Residence of Decedent  10a. State 10b. County	10	Dc. City, Town or	Location						I0d. Inside City Limits
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	11 0.3.	If Yes, spe		anic Origin? (Sp Mexican, Puerto Specify:	Rican, etc.)		Black, White,	
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Maryland	d be filed intal Hyge ed othe event,	Be	17. Father's Name (First, Middle, Last) Oscar Prosper				18	3. Mother's Name Ferna		Maiden S cker	urname)	
aryl	should and Me mark umatic	P .	19a. Informant's Name/Relationship (	Type. Print)	19b. Ma	iling Address	s (Street and	Number or Rur	-	ər, City or	Town, State, Zip	o Code)
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Baltimore,	it of Hi If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	D 11 0111	20b. Place of Dis cemetery, c.	rematory or	other place)	Sente	ember		ation - City or To esda, Ma	
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Ba	Depa Impo any		Augustis Burgu	₩0	1305 7	557 Wis	consin	Avenue, E	ethesda,	Maryla	da-Chevy and 20814	Chase, Inc. -3501
			23a. Part 1 Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final					such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Non Smal		ung Ca	ancer					
	Examiner	_	Sequentially list conditions,	b								
\%	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	onsequence or).						2.0	
Ö,	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a c	onsequence of):							
68760,	icate b physic s the b	dical		.d								
.O. Box (	ne death certifi the attending I hed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 I 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death	3⊟Ectopic p 5⊟ Other (s				23	d. Date of deliv	ery Day Year
Δ.	requires that the de een signed by the a rould be detached t	by Ph	Part II. Other significant conditions of	ontributing to death but r	not resulting in the	underlying	cause given i	in Part I.	23e. Did to	obacco us	e contribute to	the cause of death?
ords	w requires that been signed be should be det							<u> </u>	10	Yes 2□	No 3□ Pro	bably 4 🛣 Unknown
or Vital Records,	e law has b je 2 sk	Completed							24a. Was autor perfo 1∐ Yes	osv	death?	opsy findings available ompletion of cause of
ita	lcian: Th certificate ector, pag	Be Co	25. Was case referred to medical				20	6. Place of Deat			1 🗌 Yes	2∐ No
<u>r</u> <	dir dir	To B	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 🕅 Inpatient	2 ER/Outpat			4 ☐ Nursing Ho	me 5 Resi	dence 6	□Other (Speci	ify)
ion o	Jing After funet	ation:	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Time	of y M	28c. Injury at Work? 1 ☐ Yes	t s 2 □ No	28d. Describe I	how injury	occurred	
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury building, etc. (	- At home, farm, (Specify)	street, factor	ry, office		28f. Location (S City or Tox	Street and wn, State)	Number or Rui	al Route Number,
	Hospital or 24 hours afte Funeral Dir etely filled in	Medical		ysician: To the best of a niner: On the basis of ex and manner state	kamination and/or							
	To the within 24	Mec	29b. Signature and title of certifier	A A THORNEY STATE		29	c. License n	umber		29d. Date	signed (Month	, Day, Year)
)			Moure				D6725	58		Septe	ember 2	6, 2009
	12		30. Name and address of person who Nicholas J. Farre				enter	Drive	Ste 30	0. Ro	ckvi114	e, MD 20850
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's		. J	CHUCL	221409			CKATTE	, 110 20000

DHMH 17 Rev 1/2001

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JESTO, GEORGETTE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 3 per doc 8895 9-30-09 yt State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 3. Time of Death **8:27** 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Sept Physician/ 2009 Dolores Rinehart Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice  ${ t Baltimore}$ Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Min. 1 □ M 2 🛛 F Months Hours **Director** 299-26-2578 27-1920 OH Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Examiner must be notified at Director OH Columbus 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a ( Funeral 300 E. Rich St., Apt. 43215 or items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3★ Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Own Home <u>Homemaker</u> Ве 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emmett Woodrum Gladys Sheridan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Schooley-Daughter 2669 Dibblee Ave., Columbus, OH 43204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State st. 9-30-2009 Columbus, OH Joseph Cem. 4 Donation 5 Other (Specify) 21. Signature of Experal Service Licenses 22. Name and Address of Facility Bradley-Ashton Funeral Home PA 2134 Willow Spring Road. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) reumania Henry 21) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). that the death certificate be executed ig physician and as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Month Year Day Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chanic dostactive purmary 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an his certificate has b I director, page 2 sh Ortery disease autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4 Nursing Home 5 Residence 6X Other (Specify) 10501 CQ ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 ☐ Pendi*n*g 1 🗆 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R145356 26,2009 estember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tarson MO 21200 31. Date filed (Most State

Registrar

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4/26/109

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 300 AM Physician 2009 28 George T. Stroup /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Rosedal FRANKLin Square Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year)
Dec . 17, 1940 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months ^cMaryland **₩** 2□ F 68 214-38-9598 Director Usual Residence of Decedent 10d, Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No Middle River Baltimore MD Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21220 2106 Graythorn Road by Funeral death \ 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc filed within 72 hours after White 1 ☐ Yes 2XXVo Specify: 5-0036 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 2121 Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Monee. Disabled 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Marylin Thomas Arnold Stroup 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23 Maxa Court MIddle River, MD 21220 Donna Schnepf/ Daughter Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 09/30/09 |Baltimore, MD 22. Name and Address of Facility 300 Mace Ave Balto. MD Connelly FUneral Home of Essex 21221 21. Jight ture of Funet I Service Linensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease (Coronar Arter C. A.D Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-trar Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) signed by the a d be detached f I□Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed? 2 No 2 No 10 26. Place of Death (Check onl one 25. Was case referred to medical examiner? funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Hospital or Attending Injury 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DOD63327 BaizAW It. WOLDETHWOT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 3 0 2009

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STROUP

WOLDEHOWOT, MD

32. Registrar's Signature

9000 FRANKLIN SOLDT, Baltimore, m 213

			For State Registrar		State	of Maryla		artment of H			giene	09	3130
			negistrar     Decedent's Name (F	irst, Middle,	Last)					2. Date of Dea	ath		Time of Death
	Physicia /Medic		MILLER		STEVE	NS				Month SEPTEVABLE		(ear 0 9	4:50 AM
	Examin		4a. Facility Name (If no					-	r Location of Deat	h	4c. County of	Death	,
A		М	JOHNS HOPE					If Under 1 Year	) YM o K E	8. Date of Bir	th C	Rirthplace	(State or Foreign
	Funeral Director		5. Social Security Num 157-44-861	.3	S. Sex	7. Age (in yi	rs. last birthday) Yrs.	Months Days	Hours Min.	Mar. 1	, Year 939	Onio	
land	MC =	] }	Usual Residence of De 10a. State 10	b. County		10c.	City, Town or Lo	cation				10d. In	side City Limits
Mary	r-f sh	햦	MD	N/	A			Balt	imore			1-	X Yes 2 □ No
th the	or 28;	Director	10e. Street and Number					10f. Zip Code			10g. Citizen of Wh		
ath w	\$ 23a	eral	5414 Reis	sterst			us Lis		21215		United S		dian
G ZIZI3-UU30 filed within 72 hours after death with the Maryland	of Health and Mental Hygiene. Item 27 is marked other than "naturar", or items 23a or 28a-f show other traumatic event, the Medical Exerciting must be rediffed at	by Funeral	11. Marital Status 1 ☐ Never Married 3 🏋 Widowed 4 ☐		12. Was Ded Armed F 1 ∐Yes If Yes, G Year or	cedent Ever in orces? No ive Dates:		Was Decedent of In If Yes, specify Cub 1 □Yes 2X\No		specify Yes of No to Rican, etc.)	Black,  Specify:	- American In White, etc. Whit	
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d with	Mental Hygiene arked other than atic event, Inc. N	E O	Elementary/Seconda	iry (0-12)	College	(1-401 5+)	1	Enteprene				Busine	SS
<b>≘</b> ≘	d oth	Be	17. Father's Name (Fir							_{me (First, Middle)} Johnson	, Maiden Surname)	ı	
aryid	d Mer narke natic	٩	Ephram St				10h Maili	as Address (Street			er, City or Town, S	tate Zin Cod	(a)
Z 2	Health and em 27 is ma other trauma	11	Sally Stev		p (Type: FTIIII)		5414	Reisters	stown Roa	d, MD 21	1215		
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ecords, law requires t	s beer shoul	Completed								24a. Was	an 24b. W	ere autopsy f	findings available
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OT V Physic	this coal dire	P	1 ☐ Yes 2 ☑ No				☐ ER/Outpatie	nt 3 🗆 DCA			idence 6 Other		
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is is	s afte al Dire ed in b	Certification:	4 ☐ Homicide		buil	ding, etc. (Spe	ecny)			City or 10	wn, State)		
Hospit	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (			xaminer: On the						e cause(s) and mar , date and place, a		
To the	within To the comp	Me	29b. Signature and title	e of certifier		den			se number		29d. Date signed		
			1/1	an				RES	-001	-	IEPTEMBE	K 23.	2009
X	0		30. Name and address MAKGAEET C	of person v	vho completed ca 4ugH – HVIS	use of death (I	tem 23a) (Type,	Print) EASTERI	V AVENU	E BALTI	more, M	ARYLAN	10 21224
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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

John Edwin Suttor	1	- For State	State	of Maryla		artment o			Menta	al Hy		Reg. No.	00	
Physician Medical Examine	1	legistrar 1. Decedent's Name (First, I	Aiddle,La	John Ed		_				2	n. Date of Dea Month September	ath Day	Year	3. Time of Death U
		4a. Facility Name (if not inst	tution, gi			000113	4b. City, T	own, or L	ocation of	Death	Ocptemb	4c. Co	ounty of Dear	th
( )	L	Frederick Memoria	l Hosp				Frede				l : (a)		derick	(0)
Funeral Director		5. Social Security Number	6. 5		7. Age (In yrs.		If Unde	r 1 Year Days	-	Min	1		Fore	
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tells and Mental Hygiene. Iran 27 is marked other than "natural", or items 23a or 28a-f She tranmatic event, the Medical Examiner must be notified at once		19a. Informant's Name/Rela				19b. <b>Ma</b> i	ing Address	(Street			The second second		or Town, Sta	te, Zip Code)
MD and 2 shoulth and and 27 is aumati	1	Theresa Su	tton	- Wife						, Kn		e, MD	21758	3
ore, ss 1 am of Heal		20a. Method of Disposition  1 Burial 2 XCrem	ation 3	Removal fro		. Place of Disp crematory or		ne of cerr	netery,		Date		•	or Town, State
imo Page ment c		4 Donation 5 Oth	er Speci	fy:		gersto							gersto	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other transmite event, the Medical Examiner.		21. Signature of Funeral Se	rvice Lice	ensee	M00								. & Noi	
Physician	+	23a. Part I. Enter the diseas	e, or con	plus that cations that cat			uneral rthe mode o	HOII of dying, :	ne – such as ca	Harp ardiac or	respiratory a	rrest, shock	WV 254 , or heart	Approximate Interval
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68760, certificate be nding physici se as the buri	Z ME	IF FEMALE: 3b. Was decedent pregnan	t in the	23c. If yes,	outcome of pre	egnancy	Fetal death	3	Ectopic	; pregnar	ncv		Date of delive lonth	ery Day Year
ision of Vital Records, P.O. Box 6876. Attending Physician: The law requires that the death certificate death. ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the the standard of the page of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con	Physician/m	past 12 months?		4 Pregn	ant at time of o	death 5	Other (Spe		Lotopio	program		+ "		20,
Box le death of the attented for us	<u>~</u> L	1 Yes 2 No 9	Unknov	9 Olikili							[00- Did			to the course of death?
P.O.	S S	Part II. Other significant c	ondition	s contributing to	o death but not	resulting in th	e underlying	cause g	iven in Pa	rt I.				to the cause of death?  robably 4 V Unknown
duires en signald be	ered						····		-		24a. Wa			autopsy findings available
COFC law re law be be table	힐				· · · · ·			-			auto perl	opsy formed?	death'	
Re The	Compi	25. Was case referred to m	- dia al					26 Place	of Death	(Chack o	1 Yes	2 No	1 🗸	Yes 2 No
fital sician sician is cert lirecto	ן מֿ	examiner?		Hospital:	Inpatient 2	✓ ER/Outpati		_	Other ₄	,	Home 5	Residence	ce 6 Oth	ner:
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rendin eath.	<u> </u>	1 X Natural 5	Pending Investiga		, Day, rear/			1 Y	'es 2	No				
Division tal or Attendir rs after death. al Director: A led in by the fu	Certification:	3 Suicide 6	Could no	ot be 28e. Plac	e of Injury - At	home, farm, s	reet, factory	, office b	uilding, et	C.	28f. Location or Town,		Number or	Rural Route Number, City
Spital Di	5   5	4 Homicide	determir	(0,000.3)										
Division of Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Directors.	ō l	(Check only Certify)	ng Phys I Examin	ician: To the bes	of examination	edge, death oo and/or invest	curred at the gation, in my	time, da opinion	ite and pla , death oc	ice, and curred at	due to the ca t the time, dat	use(s) and i te and place	manner as st e, and due to	tated. the cause(s)
2 m 2 m	ğ	29b. Signature and title of	ertifier	and manner s	lateu.		29	c. License	e number			29d. Da	ate signed (A	Month, Day, Year)
		Pat: (	lu .	- tal	De	N		O.C.I	M.E.			Septe	ember 18,	2009
0	T	30. Name and address of p			se of death (Ite		111 D	enn St	reet Ra	ltimor	e, MD 212	01		
Sta	i e				egistrar's signa		7	J. 11 I J			-, 11111 2 12	-	-	
Registra	ar	SEP 30 2	009	Renous	p. 1	To anno								

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 Day Year S. smith

3. Time of Death

02=4/AM

2009

28

Physician	
/Medical	
/iviedical	
Examiner	

For State Registrar

David

**Funeral** Director

permit, Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exact not cuts to notify of an once.

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, 8

er	4a. Facility Name (If not institution, give	street and number)	, ,	4b. City, Town,	or Location of Dea	th	4c. County		n	•
	Good Samari	tan Haspita	7/	Dal 1	If Under 24 Hrs	Doto of Birth	7 "	A Riet	hplace (State	or Foreign
	5. Social Security Number 6. Sec. 1X	7. Age (In yrs		Months Days			Year) -1952	Cot	untry) M	
	Usual Residence of Decedent	31	5			10 11	1702			
	10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside C	
ģ	MD N/A	Ba	ltimor	e					1 X Yes	s 2∏No
<u>ire</u>	10e. Street and Number	\ <u> </u>		10f. Zip Code		1	10g. Citizen of		untry?	
ā	1401 Argyle Ave	enue		212	17		US	A		
To Be Completed by Funeral Director	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	I.S. 13. \	Was Decedent of	Hispanic Origin? (	Specify Yes or No- to Rican, etc.)		ce - Amer	rican Indian,	
Z F	1 Never Married 2 Married	1 ZAYes 2 □ No If Yes, Give	1	I∐Yes 2⊠ No		, ,		y: B1		
D	3 Widowed 4 Divorced	Year or Dates:								
ete	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Deced	lent's Usual Occu	ipation e during most of wo ed)	rking	16b. Kind of B	usiness/l	ndustry	
Ę	Elementary/Secondary (0-12) J.2th grade	College (1-4or 5+)	me. L	Disabl			Dis	abl	ed	
ပ္သ	17. Father's Name (First, Middle, Last)	2 years				me (First, Middle, i	Maiden Surnar	ne)		
ĕ	Willie Smith					Jane Sa				
=	19a. Informant's Name/Relationship (Tv	ne. Print)	19b. Mailin	a Address (Stree	nt and Number or F	lural Route Numbe	r. City or Town	State. Z	in Code)	
	Marlin Smith-H	· · ·				MD 212		, Olalo, 2		
	20a. Method of Disposition		Place of Dispo	sition (Name of natory or other pla	t f	Date	20c. Location	- City or 1	Town, State	
	XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State		natory or other pi		8-2009	Owings	s Mi	lls,	MD
	21. Signature of Funeral Service License			. Name and Addi		March	_			
	Mo a	Warner			-	th Aven			, MD	2120
	23a. Part1. Enter the disease, or compli	cations that caused the dea		er the mode of dy	ring, such as cardia	ac or respiratory arr	rest,		Approxima Interval Be	ate
	shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.			-				Onset and	etween i Death
	disease or condition resulting in death)	Hepatoœu	ular	carcin	oma			-		
		Due to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a consect of the to (or as a conse	querice oi).	-/ 0	ca ca					
e	Sequentially list conditions,	Due to (or as a conse	quence of):	ac oi.	lease					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	HONY E	ilure							
LYG	resulting in death) Last	Due to (or as a conse	quence of):			***************************************				
g		4								
Physician/Medical Examiner										
	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregr		1			23d. Da	ate of deli	ivery	
2	in the past 12 months? 1 □Yes 2 □No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		] Ectopic pregnar ] Other (specify) .			М	onth	Day	Year
70	9 □ Unknown	9 ☐ Unknown								
	Part II. Other significant conditions con		sulting in the ur	nderlying cause g	iven in Part I.	23e. Did to	bacco use con	tribute to		_
2	chronic Asc	ites				1 □ Y	es 2□No	3□ Pr	obably 4 🗖	Unknown
pe completed by	Hepatitis C	4				24a. Was a		Were au	topsy finding	s available
	TI OF POOL OF C				-	autops	med?	death?	completion of	cause of
2	25. Was case referred to medical				26 Place of De	1 ☐ Yes ath (Check only or	2 Mo	1 ☐ Yes	2 <b>12</b> No	
	examiner?	fospital: 1 Inpatient 2	] ER/Outpatien	t 3 DOA O	her:	Home 5 ☐ Resid		her (Sne	cifv)	*
-	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Inii	ury at	28d. Describe h			ony)	
2	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury		ork? ⊒Yes 2 ∐No					
3	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, stre	eet, factory, office		28f. Location (S	treet and Num	ber or Ru	ıral Route Nu	ımber,
į	4 ☐ Homicide determined	building, etc. (Spec	rry)			City or Tow	n, sare)			
Medical Certification: 10	29a. Certifier 1 Certifying Phys	sician: To the best of my kn	owledge, death	occurred at the	time, date and place	ce, and due to the	cause(s) and n	nanner as	s stated.	(-)
ב ב	(Check only 2 Medical Exami	ner: On the basis of examin and manner stated.	ation end/or in	vestigation, in my	opinion, death occ	curred at the time, o	pate and place,	and due	to the cause	(s)
Ā	29b. Signature and title of certifier			29c. Licer	se number	2	29d. Date signe	ed (Month	h, Day, Year)	
	· m	M.D.		RES	000		091	28,	1200	9
	30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type, I	1,-00						-
- 1	-1		^		-				_	

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Mont Physician 15.2005 Sodembu /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Balti more City Hospital of If Under 1 Year | If Under 24 Hrs. 9 Birthplace (State or Foreign Country) Maryland Date of Birth Wonth, Day, 8. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 M 2 □ F Months Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code #11/2 with Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 ☐ If Yes, Give Year or Dates: timore, Maryland 21215-0036 1 ☐Yes 2 No Specify Ş Q Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) <u>Boones</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Ni ece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Iolana HawKins-Vaughan 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of I Important: If its any Injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12009 Wings Mills. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kespivortor **Physician** disease or condition resulting in death) /Medical Due to (or s a consequence of): **Examiner** Pricaldi sequentially list or citions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician; The law requires that the death certificate be executed attending physician and for use as the buriaf-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 1 ∐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Stroke 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No al or Attending Physician: 1 s after death. Il Director: After this certifica ed in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number D0068650 Reliman MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINA HOSPITAL OF BALTIMORE MO TAZEEN REHMAN 31. Date filed (Month, Day, Year) _ _ -32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CYNTHIA LORRAINE SENNETT Month Day SEPTEMBER Year 2009 26 1:30PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat **TOWSON** Examiner Death BALTIMORE STELLA MARIS HOSPICE 7. Age (In yrs. last birthday)
50 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 4-21-1959 220-76-2353 Days Months Hours 1 M 2 🔀 F MARYLAND Director Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10d. Inside City Limits with the Maryland 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director MD BALTIMORE ROSEDALE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 5366 GLENTHORNE COURT 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1X Never Married 2 ☐ Married 72 hours after 1 ☐ Yes 2 X No Specify. Specify: WHITE "natural". 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n 2121 Elementary/Seconday (0-12) College (1-4 or 5+) SENIOR BUYER STATE OF MD **UMB** Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WELCH SENNETT, ELSIE MAY HARRY JR. (COKER) permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print)
ELAINE BRAGG/SISTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2137 MARDIC DRIVE FOREST HILL, MD 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) OAKLAWN CEMETERY 110-1-09 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME mature of Funeral Service Licenses 1211 CHESACO AVE ROSEDALE. 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition Onset and Death Pnysician/ Medical resulting in death) Examiner Sequentially list conditions Examine Due to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform **Director:** After this certificate It in by the funeral director, page 1 TYes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No Other: 1 Tyes 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DCA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes Investigation 6 Could not be 2 🗌 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check efflying Nurse Fractioner: To the best of my at the time 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2009 of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009

2009

# Baltimore, Maryland 21215-0036

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	_	For State Registrar		Otate of W	ai yiai ic	-	rtificate of			Reg. No.	UU:	, 91919		
Physicia /Medic		1. Decedent's Name Arthur	e (First, Middle, Las Scott	t)					2. Date of Dea Month Septe	_	24, Year	3. Time of Death 009 9:10 PM M		
Examin			_	street and number)								. County of Death  Montgomery		
Funeral		Casey He 5. Social Security N		ex 7. Ag	je (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Bir	thplace (State or Foreign		
Director		577-09-	5058	<b>№</b> M 2□ F	94	Yrs.	Months Days	Hours Min.	(Month, Da Feb 18	8, 191	.5 Ma	ryland		
land ow		Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits		
a-fsh	ctor	MD	Montgo	mery	Si	lver S	Spring					1 □Yes 2 No		
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eath v ns 23a must	Funeral	2805 Liz	ndell Str	eet 12. Was Decedent	Ever in U.S	. 13.1	20902		pecify Yes or No-			erican Indian,		
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2 shou and N is ma auma	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20, 20, 20, 20, 20, 20, 20, 20, 20, 20,													
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al or Atte s after de: I Directo	ertific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of in	jury - At hor tc. (Specify)	me, farm, str )	eet, factory, office		28f. Location (S City or Tov		lumber or F	Tural Route Number,		
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HV		30. Name and addr	ress of person who a	completed cause of a	death (Item	23a) (Type,	Print) 1 Munica	ster Mi	ll Rd.	Rock	ville	Mel 20855		
Sta Registr		31. Date filed (Mon	SEP 30 2	completed cause of a service of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the	rar's Signati	p. A	barker							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** SHORT 14:46 PAMELA SEPT. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 813 FISHER ROAD PRINCE EMPLE 1+166 MD, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2 🗷 F 110-46-320 Director 1955 NEW FEB. 8 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 es 2 No Director PRINCE GEORGE TEMPLE 10e. Street and Number 10g. Citizen of What Country? 20748 FISHER ROAD 4.5, Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 important: If item 27 is marked other than 'any injury or other traumatic event, the Manager and injury or other traumatic event, the Manager and injury or other traumatic event, the Manager and injury or other traumatic event, the Manager and injury or other traumatic event, the Manager and injury or other traumatic event, the Manager and injury or other traumatic events. Elementary/Secondary (0-12) POST OFFICE OSTAL WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental JEROME BRADLEY SHIRLEY BROWN ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1445BAND 5813 FISHER ROAD TEMPLE HILL MO 20748 EOWARD SHORT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) D-partment MAPLE GROVE CEM OCT, 3. 09 KEW GARDENS NY JOSEPH L. CANBY 22. Name and Address of Facility MARZULLO FUMERAL CHAPEL 21. Signatur of Funer 6009 HARFORD ROAD BALTIMORE, MO 21214 23a. Pr. t1. E. ret the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, if heart failure. List only one cause on each line. Immediate Lause (Fi disease of condition resulting in death) mediate Cause (Final **Physician** Due to ( r as a consequence of) /Medical DX - 01,01, 4000 Examiner cell 09.27.2009 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed uetastabic Due to (or as a consequence of) burialphysician Physician/Medical as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy perform certificate 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of 29a. Certifier

Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: completely filled in by

> State Registrar

IRING Vicitinian, M.D. 31. Date filed (Month, Day, Year) SEP 3 0 2009

Very Homeres

29b. Signature and title of certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRING Viciting, N.D. IIC INVINOS Freet Washing Ton DC 20010 32. Registrar's Sinature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number MD 0 37655 29d. Date signed (Month, Day, Year)

09,29,09

State of Maryland / Department of Health and Mental Hygiene. UUS

							Cert	ificate of		R	eg. No.	
	Physici /Medi		1. Decedent's Name (First, Mi Robert	ddle, Last)	Schla	ff				2. Date of Dee Month	Day Ye	3. Time of Death
1	Examir		4a. Facility Name (If not institu	spito	al of	Jalkin	noral Bo	Chmery	4b. City, Town, or	Location of Deeth	4c. County of I	Deeth
	Funeral Director		5. Social Security Number  375 – 40 – 9611  Usual Residence of Decedent	6. Sex	7. A	ige (In yrs. 92	last birthday) Yrs.	If Under 1 Year Months Deys		8. Date of Birth Month, Day 12-26-1	916	Birthplace (State or Foreign Country)
	show		10a. State 10b. Cou	nty		10c. Cit	ty, Town or Loc	ation				10d. Inside City Limits
	e Mar	ctor	MD BALT	IMORE		BAI	LTIMORE		- 1946			1 ☐ Yes 2 🂢 No
	ath with the 23a or 24	Funeral Director	10e. Street end Number 725 MOUNT WILS	ON LA	NE #131			10f. Zip Code 21	208	1	0g. Citizen of Wha	t Country?
050	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  It of Health and Mental Hygiene.  It diem 27 is merked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ N  XXWidowed 4 □ Divord	arried	12. Was Deceden Armed Forces 1)(1) Yes 2 If Yes, Give Yeer or Dates	] No		as Decedent of Yes, specify Cul ☐ Yes 2【X No	Hispenic Origin? (S ban, Mexicen, Puerl Specify:	pecify Yes or No- o Rican, etc.)	Black, \ Specify:	American Indian, White, etc. IHTTE
5-0	natur 72 h	15. Decedent's Education (Specify only highest grede completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)								rking	16b. Kind of Busin	ess/Industry
64	2 should be filed within 72 hours and Mental Hygieral is marked other than "natural", sumatic event, the Medical Ex-	Be Completed	Elementary/Secondary (0-1	2)	College (1-4or 5+	5+)	DENTIST		ed)		DENTISTR	Υ
Maryland	be filed tal Hygid d other event,	Be (	17. Father's Name (First, Midd JOSEPH	le, Last)		C				ne (First, Middle, I	•	CHOVED
7	should nd Men marke imaric	၉	19a. Informant's Name/Relation	nahin (Tu	no Brint)	31	CHLAFF	Address (Ctres	ESTHER	real Payete Alumbar		SHOVER
	nd 2 s lith an 27 is 1 r trau		BARBARA SCHLAF						RING AVEN			
ore,	of Head	- 1	20a. Method of Disposition				Place of Disposi cemetery, creme	tion (Neme of			20c. Location - City	
Ĕ,	Pages ment of I ant: If ite ury or o		1 Burial 2 Crematic		emoval from State	9	TH ABRAI	HAM CEMI	ETERY	09-28-200	09 DETROI	IT, MI
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signatur of Fyneral Servi	ce License		2	× 89	Name and Addr	ess of Facility SO	L LEVINS	ON & BRO	THERS, INC., MD 21208
			23a. Pert1. Enter the disease shock, or heert failure. I	or complic	cations that cause e cause on eech	ed the deet	h. Do not enter	the mode of dy	ing, such as cardiad	or respiratory arr	est,	Approximate Intervel Between
6	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	a.		Due to (o	CQC or es a consequ	Ahli ence of):	17 hunis			Onset end Death
	outed nd ransit	Examiner	Sequentially list conditions	<b>C</b> b.		Due to (o	frel or as e consequ	multil	0(36 ph	ellmon	É	
x 68760,	raw requires man me dearn certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Medicai	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Lest	<b>{</b>			r as a conseque					
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on of	nosputa or Auterioning Fripsicians. A hours after death. Funeral Director: After this certific stely filled in by the funeral director,	ion: To	1 ☐ Yes 2 ☑ No  27. Manner of Deeth 1 ☑ Natural 5 ☐ Pen	ding	28a. Date of Inj (Month, D		ER/Outpatient 28b. Time of Injury	28c. Inju			ow injury occurred	Specify)
Division	to the nexplain of Australia Franciscon Australia Franciscon after death.  To the Funeral Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Cou	stigation d not be rmined	28e. Place of Ir building, e	njury - At ho tc. <i>(Specif</i> )	ome, farm, stree			28f. Location (St City or Town		or Rural Route Number,
d'	within 24 hours and the Funeral I	edicai Ce	29a. Certifier 1 Certification (Check only one)	/ing Phyel al Examine	er: On the basis	of examina	wledge, death o tion end/or inve	occurred at the tastigation, in my	ime, date end place opinion, death occu	, and due to the carred et the time, d	ause(s) end menne ate and place, and	er as stated. due to the ceuse(s)
4	within 2 To the comple	Med	29b. Signeture and title of cert	fier	and manner s	ialed.	***************************************	29c. Licen	se number	2	9d. Date signed (N	fonth, Dey, Year)
•	- 51- 0		D/ Nem	W.	11/1	lá lite a	21-1-	RS	9-1	000	Tront.	6: 192169
			30. Name and address of pers	on who con	npleted cause of	deeth (Item	23a) (Type P	rint) . H	ospital	of Bi	atimo	Te Te
	Sta Registr		31. Date filed (Month, Day, Ye SEP & A &	r)	32. Regist	rer's Signa	ture	1.				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Oldio of W		Certificate of			eg. No.	119	31310		
	Physici	an	1. Decedent's Name (First, Middle, La Josephine A.					2. Date of Deat Month Septemb		Ye ar Q	3. Time of Death 4:34 pm		
	/Medio	i	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. County o		4:34 pm		
	<i>i</i>		2415 Girdwood				onium	To Date of Digital	Balt				
ı	Funeral Director			Sex 7.Ag	ge <i>(In yr</i> s. <i>Iast birtho</i> 83 Yr:	Months Dave	Hours Min.	8. Date of Birth July 23	Year 926	Penn:	ce (State or Foreign y) sylvania		
	and w		Usual Residence of Decedent  10a. State 10b. County	-	10c. City, Town o	r Location				10d	I. Inside City Limits		
	Maryl a-f sho	tor	MD Balt	imore	Timo	nium					1 □Yes 2X No		
	th with the 23a or 28a	al Director	10e. Street and Number 2415 Girdwood	Road		10f. Zip Code 21	093	1	0g. Citizen of Wh	nat Country	1?		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1  Yes 24 If Yes, Give Year or Dates:	No	13. Was Decedent of I If Yes, specify Cub 1 □ Yes ※ WWW.		pecify Yes or No- o Rican, etc.)	14. Race Black Specify:				
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/land	uld be file Mental Hy Irked oth	To Be	17. Father's Name (First, Middle, Last Matthew Tunile					ne (First, Middle, I a Zelin		)			
, Mar	und 2 sho alth and 1 27 is ma er traume		19a. Informant's Name/Relationship Heather Kicklie	r, City or Town, S re, MD	212	ode) 22							
Baltimore, Maryland 21215-0036	Pages 1 ament of He tant: If item		20a. Method of Disposition  1XI Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of Disposition (Name of Date Dulaney Valley 09/30/09 Timonium,										
Balt	permit Depart Import any inj		21. Signature of Funeral Service Lice	e Peu	y	22. Name and Addre	ess of Facility 300 FUnera	0 Mace 1 Home	Avenue of Ess	Bal ex 2	to. MD 21221		
	Physician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	o Renal	enter the mode of dyi	ing, such as cardiac	or respiratory arr	est,	11	Approximate Interval Between Dinset and Death		
-	Examiner			Due to (or as	a consequence of)	ino.							
0	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequence of)								
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Vita	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Otil	hor:	th (Check only on	ne)				
Jo L	ding Phys h. After this funeral di	n: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpat 28a. Date of Inj (Month, D	ient 2 ER/Outpa jury 28b. Tin ay, Year) Inju	ne of 28c. Inju	4 LI Nursing H	ome 5 ▼ Residence 128d. Describe he	ence 6 Other ow injury occurre	1 //			
Division of Vital Records,	To the Hospital or Attendir within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification: To	2 Accident investigatio 3 Suicide 6 Could not be determined	n			Yes 2□No	28f. Location (S. City or Town	treet and Numbe n, State)	r or Rural F	Route Number,		
	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier 1 Certifying P	hysician: To the bes	t of my knowledge, o	death occurred at the t	time, date and place	e, and due to the o	cause(s) and mar	nner as sta	ted.		
	the Ho hin 24 h the Fui mpletely	Medical	(Check only 2 Medical Exa	miner: On the basis and manner s	of examination and/	or investigation, in my	opinion, death occu	rred at the time, o	late and place, a	nd due to t	he cause(s)		
	To t To t	2	29b. Signature and title of certifier  Was LOW	W Qu		29c. Licen	se number 32453		29d. Date signed	(Month, Da	iy, Year)		
	10		1 1011	completed cause of	death (Item 23a) (Ty SCHILL'Y	pe, Print)	tunt Va		10 2	1031	5		
	Sta Registr		31. Date filed (Month, Day, Year) SEP 3 0 2009	32. Regist	trar's Signature	Not			111				

DHMH 17 Rev 1/2001

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ances Vogel		1- For State Registrar	tate of Maryla	and <i>i</i>		ment of ficate of			Menta		Reg. No. 2003 3131			
Physicia edical Exami	****	Decedent's Name (First, Midd Frances Loret									Date of Dea Month Septembe		Year 2009	3. Time of Death 1055 hrs
		4a. Facility Name (if not institution  Johns Hopkins Bayvie					4b. City, To		ocation of			_	County of Death	)
Funeral		5. Social Security Number	6. Sex		e (In yrs. last	birthday)		r 1 Year	If Under 2	24Hrs. 8	B. Date of Bir	th(MM/E	OD/YYYY) 9. Biri	thplace (State or
Director		216-12-2472	1 M 2 X F	85		Yrs	Months			Min	Octobe	`	Foreig	
, h		Usual Residence of Decedent  10a. State 10b. County	1		10c. City, To	ours or Loost	ion							10d, Inside City Limits
d now any		Md.			TOC. City, TO		imor	۵						1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street end Number				Dait	10f. Zip				1	0g. Citiz	en of What Cour	ntry?
h the M 3a or		4113 Balfer					<u> </u>	2121					USA	
ath wit	Funeral	11. Marital Status 1 Never Married 2 M	12. Was De larried Armed F	orces?					anic Origin Mexican, P		fy Yes or No an, etc.)	-	<ol> <li>Race - Ameri White, etc.</li> </ol>	ican Indian, Black,
ifter de	by Fu	3 Widowed 4 Div	1 Yes vorced If Yes, Give Ye		X No	1	Yes 2	No.	specify:				Specify: Wh	nite
hours a	ted b	15. Decedent's Education (Spe Elementary/Secondary (0-12)				6a. Deceden during m			on (Give kir DO NOT us			16b. K	ind of Business/I	Industry
136 thin 72 re. than	Completed	11th	College (	1-4-01 :	) )	Home	emake	r					Home	9
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho- iojury or other traumante event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle Charles Schmit						1		,	rst, Middle, I Schae		Surname)	
2127 Uld be Mental marke	o Be	19a. Informant's Name/Relations			<u> </u>	19b. Mailing	g Address	(Street					ty or Town, State	, Zip Code)
MD d 2 sho		John E. Vogel	G	rano	lson	1302							. 21113	
Baltimore, permit. Pages I an Department of Hea important: If iter		20a. Method of Disposition  1 XBurial 2 Cremation	n 3 Removal f	om Sta	ate cre	ce of Dispos matory or otl		e of cem		_	ate		ocation - City or	
ltim		4 Donation 5 Other Specify: Oak Lawn 9-30-2009 Balto. Md.												
Ba Perm Depr Imp		Schillidiek Fullerar nome											21236	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart App										Approximate Interval Between Onset and		
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as			otic Cardi	iovascul	ar Dise	ease		,			Death
	_	Sequentially list conditions,	b. Due to (or as		acuen ee eft:									
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	с											
ecuted and transit	Exa	events resulting in death) Last	Due to (or as a	a conse	equence or):									
be exectician ar	dical	UNPENDED	AMENDED											
8760 ificate I	n/Me	IF FEMALE: 23b. Was decedent pregnant in the			ne of pregnar		etal death	3 [	Ectopic p	pregnancy	,		I. Date of delivery Month	y Day Year
Box 68760, the death certificate be extitle attending physician and for use as the burial	Physician/Medi	past 12 months?  1  Yes 2  No 9  Uni	4 Preg		time of death	🖂	her (Spec	ofy)						
O. B. at the de lached f		Part II. Other significant condit			n but not resu	ulting in the u	underlying	cause gi	ven in Part	t 1.	23e. Did to	obacco u	use contribute to	the cause of death?
of Vital Records, P.O. Bing Physician: The law requires that the dAfter this certificate has been signed by the inneral director, page 2 should be detached	ed by	End Stage Renal Dis	sease											pably 4 🗹 Unknown
ords aw requas beer 2 shoul	Completed								_		24a. Was autor			topsy findings available completion of cause of
Rec : The l ificate }		25. Was case referred to medica						Of Diago	of Death (C	Thook only	1 Yes	2 🗸 No		es 2 No
Vital ysician his cert directo	o Be	examiner?	Hospital: 1	Inpatie	ent 2 🗸 EF	R/Outpatient			Othor: -	Nursing H		Resider	nce 6 Othe	r:
Division of Vital Records, P.O. at or Attending Physician: The law requires that the stard death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	Dn: T	27. Manner of Death		of Inju	iry 28 lear)	8b. Time of I	Injury 2		y at Work?		d. Describe	how inju	ry occurred	
Sior Attend or death rector: by the	icati	2 Accident Inve	estigation 28e. Pla	ce of In	jury - At home	e. farm. stre	et, factory.		es 2 N		f. Location (	Street ar	nd Number or Ru	ıral Route Number, City
Divisior ospital or Attend hours after death ineral Director:	Certification:		old not be ermined (Specify				,		<b>.</b>		or Town, S			
Division of Vital Records, P.O. Box 68760, To the Bospial or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	edical (	Concor only	Physician: To the beaminer: On the basis		-									
To t Com	Med	29b. Signature and title of certific	and manner		<del></del>				number				Date signed (Mo	
		Pote Q	- Pale	2_	~			O.C.N	Л.E.			Sept	tember 26, 2	2009
\( \theta \)		30. Name and address of persor Patricia Aronica-Polla			leath (Item 23		111 Pa	enn Str	reet Ralt	timore	MD 2120	1		
St	ate	31. Date filed (Month, Day, Year)	) 32 R		r's Signature	-		00	oot, Dail		2 120	•		
Regis		SEP 30	0000 177	ma	1 1.	do	that's							

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

**Physicia** /Medica Examine

**Funeral Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lajury or other traumatic event, it w Madical Explainment requires to notified at any lajury or other traumatic event, it w Madical Explainment requires to notified at agree.

ā	Phy	/sician ledical aminer
	/N	ledical
	EX	aminer
	_	
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 _ State	•	epartment of Heal C <i>ertificate of Dea</i>				5:510		
	Registrar  1. Decedent's Name (First, Middle, Last)		Jertificate of Dea		Reg. No. 2. Date of Death	lo.	3. Time of Death		
an	Kenneth D. Wisner					ay Year	2:45A M		
al	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca			c. County of Death	2:43A		
er	Gilchrist		Towson	and the Board		Ba1	to.		
	5. Social Security Number 6. Sex 7. Ag	je (In yrs. last birth	day) If Under 1 Year If U	nder 24 Hrs.	Date of Birth 9. Birthplace (State or Fore				
	199-20 <b>-</b> 7661 ^{1X M 2□ F}	79 Y	rs. Months Days Ho	ours Min.	(Month, Day, Year) May 7,1930 Pennsylvania				
	Usual Residence of Decedent								
7	10a. State 10b. County	10c. City, Town	or Location			1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No		
ectc	Md. Balto.	Park	ville						
ä	10e. Street and Number		10f. Zip Code		10g. (	Citizen of What Coun	itry?		
eral	1 Thomas Point Court	5	13. Was Decedent of Hispani If Yes, specify Cuban, Me			USA	1 - 1 - 2		
<b>Funeral Director</b>	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Armed Forces?  1 □ Never Married 2 □ Married	14. Race - Americ Black, White, e							
by	3 ☑ Widowed 4 ☐ Divorced Sear or Dates:	Specify: Wh	ite						
Be Completed by	15. Decedent's Education	Kind of Business/Inc	dustry						
ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or secondary)	·	Give kind of work done during life. DO NOT use retired)	most of working	7				
Son	12		el Worker		В	ethlehem_	Stee1		
Be	17. Father's Name (First, Middle, Last)		18. M		First, Middle, Maide				
မ	Roland Wisner			Flor	rence Wea	ver			
	19a. Informant's Name/Relationship (Type. Print)	19b. l	Mailing Address (Street and N	lumber or Rural	Route Number, City	or Town, State, Zip	Code)		
			Thomas Point						
	20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State	cemetery,	Disposition (Name of crematory or other place)	Dat		Location - City or To	wn, State		
	4 ☐ Donation 5 ☐ Other (Specify)	Gardens	of Faith	10-3-2		lto. Md.			
	21. Signature of Funeral Service Licensee		22. Name and Address of F						
_	Bear a Will		1	lair Rd.		gham, Md.			
. 0	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	ne.	of enter the mode of dying, such	ch as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death		
	Immediate Cause (Final disease or condition resulting in death)		100/			L	nonths		
	Due to (or as	a nsequence of	):						
ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of	);						
edical Examiner	cause. Enter Underl in Cause (Disease or injury that initiated events								
Exa		a consequence of	):						
ca	d								
Med	IF FEMALE:								
Completed by Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome	of pregnancy 2 Fetal death	3 ☐ Ectopic pregnancy			23d. Date of delive	,		
sici	in the past 12 months?  1  Yes 2 No 9 Unknown  1  Yes 2 No 9 Unknown	t time of death	5 Other (specify)			Month	Day Year		
윤	Part II. Other significant conditions contributing to death b	ut not requiting in t	ha undarluina asuas aluas in C	Post I	220 Did tobacco	use contribute to the	en anuse of death?		
و	Mustare Cancer	at not resulting in t	ne underlying cause given in r	aiti.		1/	pably 4 Unknown		
eted	10038/116				I Li tes	21/10 301100	ably 4 Oliklowii		
힏					24a. Was an autopsy	24b. Were auto prior to co death?	psy findings available mpletion of cause of		
ပိ					performed) 1 □ Yes 2 □		2 🗆 No		
Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpation		Other:	Place of Death (		<u>.</u>	1		
۲	27. Manner of Death 28a. Date of Inju	ent 2 ER/Outp	atient 3 DOA 4		e 5 ☐ Residence		n Nospia		
흝	1 Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	y, Year) Inj	me of 28c. Injury at work?  M 1 □ Yes			,,			
<u>iii</u>	3 ☐ Suicide 6 ☐ Could not be	ury - At home, farn	n, street, factory, office	28	f. Location (Street	and Number or Rura	l Route Number,		
S.	4   Homelde building, et	c. (Specify)		1	City or Town, Sta	ire)			
Medical Certification: To	29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch	of my knowledge,	death occurred at the time, da	ate and place, ar	nd due to the cause	(s) and manner as s	stated.		
edi	one) and manner st	ated.							
2	29b. Signature and tyle of certifier		29c. License num	22/32	29d. [	Date signed (Month,	Day, Year)		
			1/77		Ser	otember 1	1 2009		
	30. Name and address of person who completed cause of c	eath (Item 23a) (T		C-		(	/		
	AANON J CHANGES MM  31. Date filed (Month, Day, Year) 732. Registr	ar's Signature	N. Charles	57	10000V	( M)			
e ır	SEP 3 0 2003 Server	ar's Signature	MACO						
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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 22, **Physician** 2009 3:00 A M Teresa White /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Arbutus 1340 Stevens Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** 1958 Months Days Hours Min. 1 □ M 2√2 F Mary Land 6, Director 50 214-78**-**5206 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shool its Wedical Exercitors at Director 1 ☐ Yes 2√∑ No MD Baltimore Arbutus 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 United States 1340 Stevens Avenue by Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married White Baltimore, Maryland 21215-0036 1 □ Yes 2 📉 No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event. It also with the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control of the manual control Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shirley Hodgeson Gilbert Gray ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brandy White-O'Brien-daughter 1212 Stevens Avenue Baltimore MD 21227 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Ldudon Park Cemetery 9-25-2009 Baltimore MD 22. Name and Address of Facility 21. Signature of Funeral Service Licen Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed and use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I n signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown cate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide **Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title

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State Registrar 30. Name

31. Date filed (Month, Day, Year)

address of p

31 Registrar's Signature

parker

se of death (nem 23a) (Type/Prin

			1 - For State Registrar	State of Ma	rylan		artment of F tificate of			giene 2 () Reg. No.	109 31320
	Physici	an	1. Decedent's Name (First, Middle, La	est)					2. Date of Dea Month		3. Time of Death Year
	/Medic	al	As Escility Name (If not institution air	Brenda	Pat	ricia	Willia	ms r Location of Death	L		
	Examin	er	4a. Facility Name (If not institution, given the second	h Medical	Ce	nter	4b. City, Town, 0		son	4c. County	Baltimore
	Funeral Director		219-20-0094	Sex 7.Age	(In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt 7-26-	1941	9. Birthplace (State or Foreign Country) MD
	/land		Usual Residence of Decedent  10a. State  10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	e Man a-fsh	ctor	MD	N/A	Ва	ltimo	re				1 X Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	Vhat Country?
	s 23a		1523 N. Carol				2121			U S A	
5-0036	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. dother than "natural", or items 23a or 28a-f show event, it is it is it is a featural.	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:		- 1	Vas Decedent of F f Yes, specify Cuba I □ Yes 24 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black	e - American Indian, k, White, etc. : Black
2	"natu	lete	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	lent's Usual Occup kind of work done	durina most of work	ring	16b. Kind of Bu	siness/Industry
717	withir iene. <b>than</b>	Completed	Elementary/Secondary (0-12)	College (1-4or 5+ N / A		Telec	OO NOT use retired Ommunic	ation O	per		Memorial
פר	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last		1			18. Mother's Nam	e (First, Middle,		spital ^{e)}
Maryland		To E	Landres Smith					Esther	Mallo	rv	
Jar	12 sho	1	19a. Informant's Name/Relationship		and	19b. Mailin	g Address (Street	and Number or Rui			State, Zip Code)
_	is 1 and 2 should of Health and Mer item 27 is marke other traumatic		Robert H. Will 20a. Method of Disposition	lams,Jr	20h Pl	1523	N. Car	oline S	treet	Balto,	MD 21213 City or Town, State
Ē	Pages nent of ant: If its ary or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		C	emetery, crem	natory or other place Memori	ce) ;	3-2009		
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Lice		AL		. Name and Addre			ast F/H	
ñ			Mladys	wan	م	24	1101 E	. North			
		3 0	23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	the death	. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
÷ [	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	SEPSI:							Onset and Death
	Examiner			Due to (or as a	consequ TAT	ence of): [C SM/	ALL CELI	CARCIN	NOMA OF	LUNG	
	D +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequ	ence of):					
6	ecute and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
00/00	icate be executed physician and the burial-transit	al E	rossing in askin, East	Due to (or as a	consequ	ence ot):					
00	= 50%	edical		d							
.O. DOX	Aroptria or Attending Prysician: The law requires that the death cert Funeral Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	P □ Fetal	death 3 [	Ectopic pregnanc	у		23d. Date Mor	e of delivery nth Day Year
'n	es tha gned se det	by P	Part II. Other significant conditions	_	not resu	lting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contri	ibute to the cause of death?
SD -	w requir been s should I		RESPIRATORY						1 🗆 Y	es 2 No	3 ☐ Probably 4 ☐ Unknown
ומון שבני	iclan: The law certificate has b ector, page 2 st	Completed	CORONARY ARTI	ERY DISEA	SE				24a. Was a autop perfor 1 □ Yes	sy p med? d	Vere autopsy findings available prior to completion of cause of leath?  ☐ Yes No
<b>=</b>	s certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	+ 2 🗆	ER/Outpatien	Oth	er:			<u> </u>
5 7	ding Physician: h. After this certific funeral director,	n: To	27. Manner of Death	28a. Date of Injury (Month, Day,	, T	28b. Time of Injury	28c. Injur Work			lence 6 Other	
5	eath.  or: Af the fur	catio	1 Natural 5 Pending 2 Accident investigation	1	rear)	пусту		Yes 2 □ No			
	putal or Attendous after death eral Director: , filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc.	(Specify				City or Tow	n, State)	er or Rural Route Number,
	ple ple	Medical	one) Medical Exam	nysician: To the best of niner: On the basis of and manner state	examinat	vledge, death ion and/or inv	restigation, in my o	pinion, death occur	red at the time, o	date and place, a	and due to the cause(s)
,	CG 74 W. 5	-	29b. Signature and title of certifier	La 1	MD		29c. Licens	e number +12134		29d. Date signed	(Month, Day, Year)
•	0	-	30. Name and address of person who	completed cause of de-	ath (Item	23a) (Type E		T 4.1 (3) *Y		7/6	8/01
	8						DRIVE	TOWSON.	MARYLA	MD	
	Stat		31. Date filed (Month, Day, Year)	32. Registrar							
	Registra	ır	SEP 3 0 2009	Comme 1	11						

more, Maryland 21215-0036

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a <del>t</del>	permit. Departn Importa any inju		21. Signature of Funeral Service Licer	see	- :
<u> </u>	permi Depa Impo any ii		& lady	e Waner	
			23a. Part 1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the death.	Do not e
	Dhyoisian		Immediate Cause (Final		
	Physician /Medical		disease or condition resulting in death)	.a. Multisystem	
4	Examiner			Due to (or as a consequen	ice of):
	LXammer	,	Sequentially list conditions,	b. Sepsis	
	D +	ne.	cause. Enter Underlying Cause (Disease or injury	Due to or as a consequen	ice of:
. In	oute Id ansi	Ē	Cause (Disease or injury that initiated events	c. Extreme pre	emat
Mo	exec n an ial-tr	Ě	resulting in death) Last	Due to (or as a consequen	
9	sicia bur	ā			
87	icate phys	g		, C	
×	ding se as	Me.	IF FEMALE:	00- 16	
9	ath c	an	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de	
. E	de de de de de de de de de de de de de d	Sici	1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time of deat 9 ☐ Unknown	th 5
Ŏ.	t the by th	چ	9 🗆 Unknown	o El Grinnonni	
- 45	s tha	Σ.	Part II. Other significant conditions of	ontributing to death but not resulting	ng in the
ğ	d big	d d	Severe chroni	c lung diseas	se .
Ö	red bee	ete		_	
ě	has e 2 s	ld l			
bivision of Vital Records, P.O. Box 68760	To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has beert gigned by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner			
<u> </u>	striffic ctor,	Be	25. Was case referred to medical examiner?		
>	ysic is ce dire		1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER	l/Outpati
0	g Ph er th eral	=	27. Manner of Death		b. Time
0	fun Aft	잁	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	Injury
S	dea ctor y the	ica	3 ☐ Suicide 6 ☐ Could not be		farm s
.≥	or A	Ę	4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, 10,111, 0
	urs aurs aral t	Medical Certification: To		<u> </u>	
	Hosp 4 ho Fune ely f	cal	(Check only 2 Medical Exan	nysician: To the best of my knowle niner: On the basis of examination	
	the Find 2 the Find 2 the Find 1	ed	one)	and manner stated.	
	10 with 00 mo	Σ	29b. Signature and tile of certifier	$\Omega$ 1	
-			KIMIN	(KV)	
V	(0.1		30. Name and address of person who	completed cause of death (Item 23	Ra) (Type
	4				I. Ch
	Cha		31, Date filed (Month, Day, Year)	32. Registrar's Signature	
	Sta Registr	_	CED 3 0 2000	Muse A. D.	arks
-	riegisti	ш	3EL 9 0 5003	A Land	

	1 - State Registrar		C	ertificate of De	ath		Reg. No.	11.9	3   32	
	1. Decedent's Name (First, Middle, L	.ast)				2. Date of De Month	ath Day	Year	3. Time of Death	
in al	KHALTIL LA	MAR WA	LKER			Septer			009 14:20 ^M	
aı er	4a. Facility Name (If not institution, g			4b. City, Town, or Loc	ation of Deat		4c. County of Death			
	Greater Balti	more Medi	cal Con	ter TOW	MOS		Baltimore			
_			e (In yrs. last birthd	ay) If Under 1 Year   If	Under 24 Hrs			9. Birt	thplace (State or Foreign	
	216-85-9917	1 M 2 □ F	Yrs		lours Min.				ountry)	
	Usual Residence of Decedent			65		17/26	09	IMar	ryland	
	10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits	
ò	1470	NT / 7	Balto						1 Yes 2 □ No	
ec	MD 10e. Street and Number	N/A	Balto	10f, Zip Code			10g Citiz	en of What Co	yuntru?	
ä				21206			•	S A	ourid y :	
<u>ra</u>	6006 Belle Vi									
une	11. Marital Status	12. Was Decedent : Armed Forces?	Ever in U.S. 1	<ol><li>Was Decedent of Hispa If Yes, specify Cuban, N</li></ol>	nic Origin? (S fexican, Puer	Specify Ye's or No to Rican, etc.)	)- 1	<ol> <li>Race - Ame Black, White</li> </ol>		
Ē	1 XNever Married 2 Married	1 □Yes 2 🔯 i If Yes, Give	No		pecify:				,	
q p	3 Widowed 4 Divorced	Year or Dates:					- '	E	Black	
Be Completed by Funeral Director	15. Decedent's (Specify only highest of	Education	16a. De	cedent's Usual Occupation ive kind of work done during the control of work done during the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the cont	n a most of wo	rkina	16b. Kin	d of Business/	Industry N/A	
du	Elementary/Secondary (0-12)	College (1-4or 5	i+) [if	e. DO NOT use retired)	<b>y</b>	9			-1, 11	
į	N/A		N/A	INFANT						
3e (	17. Father's Name (First, Middle, La					me (First, Middle		Surname)		
일	Jhronne Wall	rer		\	eria	Horton				
	19a. Informant's Name/Relationship	(Type. Print)	19b. M	ailing Address (Street and	Number or R	ural Route Numb	er, City or	Town, State,	Zip Code)	
	Veria Horton-	-Mother	60	006 Belle N	Iista	Avenue	Ва	lto,	MD 21206	
	20a. Method of Disposition			sposition (Name of crematory or other place)	1	Date		ation - City or	Town, State	
	1 Burial 2 ☐ Cremation 3							•		
	4 ☐ Donation 5 ☐ Other (Spec		King M	Memorial P		-5-2009			TOWN, MD	
	21. Signature of Funeral Service Lic	ensee		22. Name and Address of		March E			01000	
	_ Dlade	e wa	الم	1101 E.	North	n Avenu	e E	Balto,	MD 21202	
ij	23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do not ne.	enter the mode of dying, s	uch as cardia	c or respiratory a	rrest,		Approximate Interval Between	
	Immediate Cause (Final			6.:1					Onset and Death	
	disease or condition resulting in death)		YSTEM O. a consequence of):	rgan failu	re				3 Days	
									7 D	
ē	Sequentially list conditions,	b. Sepsis	a consequence of:						7 Days	
in.	Sequentially list conditions, it is a list of the cause. Enter Underlying Cause (Disease or injury that initiated events								0 M + 1	
xar	that initiated events resulting in death) Last		e prema	turity at	oirtn				2 Months	
Be Completed by Physician/Medical Examiner		220 10 (0. 20	a 301103qua1103 01,71							
di		d								
Me	IF FEMALE:									
an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		3 Ectopic pregnancy			2:	3d. Date of del	,	
sici	1 ☐ Yes 2 ☐ No	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 Other (specify)				WOTH	Day Year	
ř	9 Unknown	0 2 0 111110 1111								
×	Part II. Other significant conditions	contributing to death be	ut not resulting in the	e underlying cause given ir	Part I.	23e. Did 1	obacco us	e contribute to	the cause of death?	
ğ	Severe chron	<u>ic lung d</u>	<u>isease</u>			1 🗆 '	Yes 2	No 3□Pi	robably 4 🗆 Unknown	
et						24a. Was	an	24b. Were au	utopsy findings available	
Ē						auto		prior to death?	completion of cause of	
ပိ						1,□Yes	2 🗌 No		2 □ No	
Be	25. Was case referred to medical examiner?	Hospital:		26	Place of De	ath (Check only o	one)			
ို	1 Yes 2 No	12 Inpatie		tient 3 DOA	1 ☐ Nursing I	Home 5 ☐ Resi			ecify)	
o	27. Manner of Death  ↑ Natural 5 Pending	28a. Date of Inju (Month, Da	ry 28b. Time y, <i>Year)</i> Injur	y Work?	_	28d. Describe	how injury	occurred		
cati	2 Accident Investigati 3 Suicide 6 Could not	ho	- A		2 □ No					
Ě	3 ☐ Sulcide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (	Street and wn, State)	Number or Ru	ural Route Number,	
Ş							,			
g	29a. Certifier 1 Certifying I	Physician: To the best	of my knowledge, de	eath occurred at the time,	date and plac	e, and due to the	cause(s)	and manner a	s stated.	
Medical Certification: To	one)	aminer: On the basis o and manner sta	ited.	r investigation, in my opinie	m, death occ	urred at the time,	uate and	piace, and due	e to the cause(s)	
ž	29b. Signature and the of certifier	$\bigcirc$ 1		29c. License nu	mber		29d. Date	signed (Mont	h, Day, Year)	
	KOMITA	NUL_		D2774	)		9/20	9/09		
	30. Name and address of person wh	o completed cause of d	eath (Item 22a) /T		~		212-	, 05		

David Leroy Week	1	- For State	State o	of Maryland	/ Departme			d Menta		eg. No. 2 (	309	31322
Physician	1		(First, Middle,Last)						Date of Dea     Month	th Day Ye		3. Time of Death 2227 hrs
Medical Examine		DAVII	onot institution, give		WEEKS	T 41	o. City, Town, or	Location of I		er 25, 2009 4c. County	of Death	2227 1115
1.		1232 Hilldale		ottoot and named	,		Rosedale	sedale Baltimore			re Cour	nty
Funeral Director	Ī	5. Social Security N 220 - 30 -		7. A	ge (In yrs. last birt 7 4	hday) 1 Yrs.	Months Days Hours Min				(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD	
		Usual Residence of	Decedent									10d. Inside City Limits
w any		10a. State MD	10b. County	TIMORE	10c. City, Town	or Locatio	n ROSED <i>I</i>	AT.F				1 Yes 2 No
the Maryland to 28a-f sh	3	10e. Street and Nur					10f. Zip Code		1	l0g. Citizen of W	/hat Coun	
the Ma n or 28 tiffied a	2	1232 H	LLDALE	AVENUE			2	1237		U.	S.A.	
r death with the Maryland or items 23a or 28a-f show any must he notified at once.		11. Marital Status		12. Was Deceder Armed Forces					? ( Specify Yes or No uerto Rican, etc.)	o- 14. Rac		an Indian, Black,
or death	runeral	rue-ta	ed 2 Married	1X Yes	2 No		Yes 2 X No		,	Specify.	7.77	I T T D D
tural",		3 Widowed  15. Decedent's Ed	lucation (Specify onl	or Dates: 9 y highest grade co	ompleted) 16a.	Decedent	s Usual Occupat	ion (Give kir		16b. Kind of E	AAT	HITE ndustry
72 hot 72 hot al Exa	Completed	Elementary/Seco	ndary (0-12)	College (1-4 or	r 5+)		st of working life.					_
within iene.	E L	12	(F) 1 PK 141 - 1 - 14				LOADING		KS Name (First, Middle,		SKA	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	2 0	17. Father's Name ( MALCOL)	I I I I I I I I I I I I I I I I I I I	WEE	CKS			GRA		Walder Gurran		SSETTA)
nore, MD 21215-0036  ages 1 and 2 should be filed within 72 hours after death with the Maryland and of Health and Maral Hygerer. If Item 27 is marked other than "matural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once TO Bo Completed by European Director	9	19a. Informant's Na STACEY	me/Relationship (Ty NORTON /	rpe, Print ) GRANDDA	UGHTER	Mailing	Address (Stree	t and Numbe	er or Rural Route Nu	mber, City or To		
e, M and 2 Health item 2	ŀ	20a. Method of Disp	position		20b. Place of		tion (Name of cer		Date	20c. Location		
MOF Pages ent of nt: If			Cremation 3 Other Specify:	Removal from S	, late	•	EMATORY	,	10-3-09	CATON	SVII	LLE, MD
Baltimore, permit. Pages   ar Department of Hee Important: If ite	Ì	21 Signature Fu	neral ervice Licens	see ( 🗲		22. N	ame and Address	of Facility	CVACH/RO			NERAL HOME
	1	23a Part I Enter th	e disease or compl	ications that cause	ed the death. Do no		11 CHES		AVE ROS diac or respiratory ar	EDALE,		21237 Approximate Interval
Physician /Medical		failure. List on	ly one cause on eac				g,					Between Onset and Death
xaminer	1	Immediate Cause ( or condition resulting		Oue to (or as a con								
	_	Sequentially list co	nditions, b	Oue to (or as a con	sequence of):							
	Examine	cause. Enter Unde	erlying Cause									
ted ansit	Ľ Ka	events resulting in	death) Last [[] d.	Due to (or as a con	isequence of):							
e be executed sysician and burial - transit	edical	UNPENDED		AMENDED								
68760, certificate be nding physicise as the burn	ğ	IF FEMALE: 23b. Was decedent	pregnant in the	23c. If yes, outc	ome of pregnancy			Ectopic r		23d. Date Month		ay Year
Sox 6876 leath certificate e attending phy for use as the b	Clar	past 12 months	?		at time a set also atta		al death 3 ner (Specify)	Ectopic (	ледпансу	Mortar	D	real real
BOX (ne death control to the attent hed for use	Physician/M		No 9 Unknown	9 Unknown	oth but not condition	g in the u	ndarlying sausa	vivon in Port	1 23e Did	tobacco use con	atribute to	the cause of death?
ires that the signed by 1 be detach	ਨ∣	Part II. Other signi	ncant conditions	contributing to dea	atti but not resultin	g in the u	nderlying cause (	given in Fait				ably 4 Unknown
rds, require been signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of th	Completed								24a. Was		. Were au	topsy findings available ompletion of cause of
Recol The law cate has l	틹								perf	ormed?	death?	
tal Rection: The certificate ector, page	္တ အ	25. Was case refer	<u> </u>				26.Place		Check only one)			
"Nysici			2 No			utpatient			Nursing Home 5	Residence 6		Scene
n of oding Plan.		<ul><li>27. Manner of Deat</li><li>1 Natural</li></ul>	n 5 Pending	28a. Date of Ir FOUND: Day	r ^(Year) FO	Time of Ir JND:		ry at Work? Yes   2 <b>√</b> 1	Subject as		mea	
Division of Vital Records, rat or Attending Physician: The law requirer as after death.  Al Director: After this certificate has been single in by the funeral director, page 2 should be as a factor of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	<u>ğ</u>	2 Accident	Investigation  6 Could not be	28e Place of	09   222 Injury - At home, f	2 hrs arm, stree	t, factory, office t	ouilding, etc.			nber or Ru	ral Route Number, City
Division  Hospital or Attent 24 hours after death Funeral Director: retly filled in by the	Certification	4 V Homicide	determined		esidence				or Town, 1232 Hilldale	e Avenue , Ro	sedale , I	MD
	Medical (	29a. Certifier (Check only one) 2	Certifying Physici Medical Examiner	On the basis of e	kamination and/or	ath occur investigat	red at the time, d ion, in my opinior	ate and plac n, death occ	ce, and due to the cau urred at the time, date	use(s) and mann e and place, and	er as state due to th	ed. e cause(s)
To To Con	Š	29b. Signature and	title of certifier	and manner state	) .		29c. Licens	se number		29d. Date sig	gned (Mo	nth, Day, Year)
		tatru	i We	mi-Te	Slate	m	O.C.	M.E.		Septemb	er 26, 2	009
10,1	ļ		ess of person who denica-Pollak MD		f death (Item 23a) Medical Exan	niner	111 Penn S	treet, Bal	timore, MD 212	01		
Sta	te	31. Date filed (Mon	ED Year)	32. yegis	trar's Signature	-						
Registr	GIL		LI 0 0 20	US Johns	un p.	gra						
DHMH 17 Rev 1/200	J1				OF	RÍGINA	L					

			For AMEND#18 per FH State of Maryland / Dep 1- Registrar 9/21/09 AACO HEALIH DEPT. CMH Ce	artment of Health and M rtificate of Death		ene 2009	31323
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Years	3. Time of Death
	hysicia/ Medic/		James Curtis Anderson Jr.		September	93 2009	9: 22a M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1.	4c. County of Death	
			Doctor's Community Hospital	Lanham If Under 1 Year   If Under 24 Hrs.		Prince Geo	
	uneral		5. Social Security Number  6. Sex 1 □ XM 2 □ F  7. Age (In yrs. last birthday 64 Yrs.	If Under 1 Year   If Under 24 Hrs.     Months Days Hours Min.	8. Date of Birth (Month, Day, Y November	ear) 7 1944 Count	ace (State or Foreign PA
	rector		Usual Residence of Decedent		NOVEMBEL	17,17	- IA
ylano	how	.	10a. State 10b. County 10c. City, Town or L	ocation		10	d. Inside City Limits
e Mar	a-f s	cto	MD Prince Georges Glenn	Dale			1 XYes 2 ☐ No
£	or 28	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Count	ry?
ath w	s 23a	ral	10711 Larch Drive	20769		USA	
and 21215-0036 be filed within 72 hours after death with the Maryland ntal tygiene.	Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified all once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F  1 □Yes 2 ☒ No Specify:	cify Yes or No- Rican, etc.)	14. Race - America Black, White, et Specify: Whi	tc.
21215-0036 id within 72 hours aft rgiene.	n "natur	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation he kind of work done during most of workin DO NOT use retired)	ng   16	6b. Kind of Business/Inde	ıstry
212 d with giene	t ta	mo	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Comp	uter Programmer		Private	
nd e filec al Hyg	othe vent,	Be C	17. Father's Name (First, Middle, Last)	18 Mother's Name Ruth Ca	(First, Middle, Ma	iden Surname) Rhine	
Maryland Id 2 should be file Ith and Mental Hy	arkec atlc e	횬	James Curtis Anderson Sr.		nderson		
Aar 2 shc 1 and	'Is m			ng Address (Street and Number or Rura		•	Code)
e, l	em 27 ther t				nnDale, N	MD 20769 bc. Location - City or Tov	un Stata
nor ages nt of	or o		IDBuild 2 E-Cremation 3 E Hernovariron State   A+1 a++1	matory or other place)	/2009	Glen Burni	
Baltimore, permit. Pages 1 an Department of Hea	ortani injury		4 Donation 3 Dottler (Specify)	O Alexandra and Address of Facility			
Dep Tied	any ir			Robe 16000 Annapolis R			5
*			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	1 0	d 50		Approximate Interval Between Onset and Death
	sician edical		Immediate Cause (Final disease or condition resulting in death)	ardial Int	orc tio	2n	
	miner		Due to (or as a confequence of):	010			
44	1119	Je.	Sequerately list conditions, if any, leading to immediate gause. Enter Underlying	Uri			
cuted	ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c				
8760, cate be executed	physician and the burial-transit	EX	resulting in death) Last  Due to (or as a consequence of):				
8760, cate be ex	the bu	dical	d				
× ertiff	ding p	/Mec	IF FEMALE:				\- <u></u>
I Records, P.O. Box 6 The law requires that the death certifi	the attending pred for use as	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver	ry Day Year
that t	signed by the s	Ph	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did tobar	cco use contribute to the	e cause of death?
ords	s been sign should be	2			1 ☐ Yes	2 No 3 Proba	ably 4 Unknown
Vital Records, sician: The law requires the	ate has	Completed			24a. Was an autopsy performe 1 □Yes 2 [	/ prior to con	osy findings available inpletion of cause of 2 No
Vit Siciai	recto	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ FR/Outpatient	26. Place of Death			
o Phy	er this	7: To	27. Man or of Death 28a. Date of Injury 28b. Time of	AL Nursing Hon	ne 5 ∐ Residence 28d. Describe how	ce 6 ☐ Other (Specify injury occurred	)
	r: After i	atio	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		•	
Division of Vita To the Hospital or Attending Physician: within 24 hours after death.	eral Director: filled in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
he Hospil in 24 hour	To the Funers completely fill	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal carrier on the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cau ed at the time, date	use(s) and manner as st e and place, and due to	ated. the cause(s)
Tot	<b>To t</b>	Σ	29b. Signature and tive of certifier	29c. License number	290	d. Date signed (Month, E	Pay, Year)
	. (	}	30. Name and address of person who completed cause of death (Item 23a) (Type,				
(H)	4		The Royce Burns, 8118 Good Luc	K Rd., Lanham.	MD. 2	20706	
* , F	Stat Registra	te ar	31. Date filed (Month, Day, Year) SEP 15 2009 32. Registrar's Signature S.	bares			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Philip Glenn Alter, Jr. 7:10  $P^{M}$ 10, September 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 X M 2 □ F Months 213-76-9737 50 12/12/1958 Marvland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It of Medical Examinar must be neithful at 1 ☐ Yes 2 No Anne Arundel Churchton Funeral Director Maryland the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20733 5712 Great Oak Parkway 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ▼ Married 1 □Yes 21☑No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Technician vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Kathryn White Philip G. Alter, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is or other trai 5712 Great Oak Pkwy., Churchton, MD 20733 Vicki A. Alter/ Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages Department o Important: If i any injury or once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9-12-09 Kalas Crematory Edgewater, MD 4 □ Donation 15 □ Other (Specify) 21. Signature of Fundal Price Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Walle 2973 Solomons Island Rd, Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician recrotizing disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the buriat-trar Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? Month 5 ☐ Other (specify) been signed by the should be detached 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dhocyti 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has t funeral director, page 2 s autopsy performed? 1 □Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1☐Inpatient 2☐ER/Outpatient 3☐DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 ☐ Accident 5 Pending investigation ours after death.
neral Director; Af
filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours a

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

(Check only one)

29b. Signature and title

of certifie

and address of person

leted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

ND

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** EVELYN VIRTS BURDETTE 11:42 AM September 25, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 26, 1919 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕱 E 89 218-12-2431 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Modical Event in at the published anone. items 23a or 28a-f show Frederick Director Frederick 1 ☐Yes 2 No. Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21704 United States 5955 Quinn Orchard Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: 2 Specify: 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) County Government Land Title Researcher 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) Georgana Demude Arthur Granville Virts ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18709 Mary Flowers Way, Hagerstown, Maryland 21740 John G. Burdette / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 29, 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery 2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Cardiogenic disease or condition resulting in death) /Medical Due to (or as a shequence of): Examiner Myocardia Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of) Box 68760 attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ∐Yes 2 K∏No o. 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Division 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Hospital e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69430 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ial Hospital ICU AliGon Nega rederickM State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Sept. 16, 7:05 A Shirley BUTAN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Brighton Gardens If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Ye 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year 928 New Tersey Months Hours Days 81 148-14-6859 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Palm Beach Palm Beach Gardens 1 ☐ Yes 2 No Florida 10e. Street and Number 424 Woodview Circle 10f. Zip Code 10g, Citizen of What Country? 33418 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceue. Armed Forces? ¹ □Yes 2 \ No 14. Race - American Indian, Was Decedent Ever in U.S. 1 Yes 2 N If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 □Yes 2 No Specify 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trade Exhibitions Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida Siegel Jacob Levine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 424 Woodview Circle, Palm Beach Gardens, FL 19a. Informant's Name/Relationship (Type. Print) 33418 Dr. Jay Butan, Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Eternal Light Mem. Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Boynton Beach, FL 09/21/09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fin ral Service Licensee 101008 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

254 Carroll St. NW Washington, DC

Approximate Interval Between Conset and Death Immediate Cause (Final disease or condition resulting in death) Pancreatic Cancer Due to (or as a consequence of) Lung metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Respiratory Failure Due to (or as a consequence of) IF FEMALE: te of delivery Day nth Year tribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 ∐Yes 2 🗖 №0 Assisted

**Physician** /Medical Examiner

permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 Is
any injury or other trau

Physician

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

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7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examinar must be notified

72 hours after death

and 2 should be filed within itealth and Mental Hygiene.
m 27 Is marked other than "

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar been signed by the should be detached

director, this

Completed by Physician/Medical Be Certification: To

Medical

ne

Exam

Physician: The law requires that the death certificate be executed Hospital or Attending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu

Division of Vital Records, P.O. Box 68760

23b. Was decedent pregnant in the past 12ynonths? 1 □ Yes 2 □ No 9 □ Unknown	1   Live birth 2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown	23d. Date of delivery  Month Day Yea
Part II. Other significant conditions	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat
		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unk
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings ava prior to completion of caus death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	26. Place of Death (	
1 Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home	e 5 Residence o Other (Specify) Assist
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	( <i>Month, Ďay, Year)</i> Injury Work? n M 1 ☐ Yes 2 ☐ No	3d. Describe how injury occurred LTV1ng
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street and Number or Rural Route Number City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifies

D 53691

29d. Date signed (Month, Day, Year) September 16, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #110, Rockville, MD Ajay Reddy, M.D., 3200 Tower Oaks Blvd., #110, Rockville, MD 20852

State Registrar 31. Date filed (Month, Day, Year)

29a. Certifier

(Check only



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 20:06PM Clarke STOWN September 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Park Montgomer 9. Birthplace Washingtov

5. Social Security Number akoma Hospita 9. Birthplace (State or Foreign Country) Washington, DC 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Funeral Min. 1□ M 2☑ F 8 Months Days Hours 78-32-624 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director Park 1 ☐ Yes 2 ☐ No Koma 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20913 initer Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: Completed by 3 ₩idowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Yriva bmemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be l Item 27 is marked r other traumatic e ပ unknown 19a. Informant's Name/Relationship (Type. Print) Grand Double: 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alabama Sherese Wash 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If Ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9-18-2009 Riverdale 4 ☐ Donation 5 ☐ Other (Specify) 22. Name an Address of Facility Gene Sis Crematical And Function Signature of Funeral Service Licenses NW Washington, DC a0011 Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARRYTHMIAS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UNG CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit CORONAR and Due to (or as a consequence of) P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' this certificate 2 AH0 1 ☐ Yes 2 1 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To hours after death.

Ineral Director: After this y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MAmmi D59284 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHAWN SHAWIM, MD, WASHINGTON ADVENTIST HOLP, TANOMA PARK, MD-20912

State Registrar

31. Date filed (Month, Day, Year) SEP 16 2009

32 Registrar's Signature

De was B. Sparks

		1 - For State Registrar		State of	Marylar		artmen rtificat			and M	1ental Hy	/giene Reg. No		THE	2	1-2-0
Physic		1. Decedent's Name	e K. B.	. ,							2. Date of De Month Septem	eath	· · · · ·	Ye ar 2009	3. Time 6	of Death
/Med Exami		Holy Cro	ss Hos	n, give street and num.	ber)		Silv	er S	Location o	of Death		4c.	. County	of Death		, 11
Funeral Director		5. Social Security N 092-12-8 Usual Residence of	480	6. Sex 7	7. Age (In yrs. 85	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min	8. Date of Bir (Month, Di 09/25/	rth		9. Birthpl Coun	ace (State	or Foreign
death with the Maryland	ctor	10a. State MD	10b. County Montigo	omery		ty, Town or Lo			•	-						City Limits s 2∏No
th with th	al Director	10e. Street and Nur 8484 16t		et, #705			10f. Zip	Code 910				10g. Cit		What Count	ry?	
- <b>E</b>	d by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	-	12. Was Deced Armed Force 1 □ Yes 2 If Yes, Give Year or Dat	es? 2 ☑ No		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto If 1 ☐ Yes 2 ☑ No Specify:			ecify Yes or No Rican, etc.)	0-		ce - America ck, White, e		<b>;</b>	
2 E . E	Completed	(Spec		's Education tt grade completed) College (1-4	lor 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)  Homemaker				ing			usiness/Ind	ustry		
land le file fental Hy ked otheric event	To Be	17. Father's Name (		Last)							(First, Middle	, Maiden	Surnan	ne)		
ore, Maryland 21 s 1 and 2 should be filed wit of Health and Mental Hygienn item 27 is marked other thi	-	Pax Kneitman Evelyn Lehr  19a. Informant's Name/Relationship (Type. Print)  Sidney Bloom-Husband  19b. Mailing Address (Street and Number or Rural Route Number, City  8484 16th Street, #705 Silver Silver												0		
Fe, 1 ar		20a. Method of Disp	oosition Cremation	3 ☐ Removal from St		Place of Dispo cemetery, cren t • Leba	sition (Nan natory or o	ne of ther place	e) ¦	C	ate	20c. Lo	ocation -	City or Tov	vn, State	
Baltimo permit. Pages Department of Important: If I any injury or once.		21. Signature of Fo	neral Service	Densee Mail	63	22	. Name an Chape	d Addres	s of Facility	Dan 117 Roc	zansky- O Rocky kville,	-Gold	her	o Mem	•	
S8760, licate be executed Examiner physician and s the burial-transit	dical Examiner	shock, or hear disease or condition resulting in death)  Sequentially list cor if any leading to im cause. Enter under Cause (Disease or that initiated events resulting in death) L	rt failure. List in Final in in in in in in in in in in in in in	b. Due to (or Sepsi Due to (or Bilat	ch line. Respiras a conseq Ls r as a conseq	iratory uence of): uence of): Pneumon	r Fail		y, sucii as	cardiac	л геѕрігатогу а	arrest,			Approxima Interval Be Onset and	etween
Geath certil death certil e attending d for use a	Completed by Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the past 12 if the	months?		th 2□ Feta nt at time of o	I death 3	Ectopic pr Other (sp							te of delive	ry Day	Year
I Records, P.O. The law requires that the de ate has been signed by the apage 2 should be detached it.	ed by Pi			ns contributing to dear										tribute to the		
Vital Records, sician: The law requires th certificate has been signe rector, page 2 should be d				Hypothyroi	dism						24a. Was auto perfo 1 □Yes			Were autop prior to com death? 1 □Yes	sy findings apletion of 2  No	available cause of
Vision of Attending Phy. Fr death. ector: After this by the funeral di	Certification: To Be	25. Was case referred to medical examiner?						3c. Injury Work′ 1 □ Y	r: 4 □ Nu	rsing Hor	me 5 Resi 28d. Describe 28f. Location ( City or Total	idence how injur	y occurr	red		mber,
Dji To the Hospital or within 24 hours affe To the Funeral Dir completely filled in	Medical Ce	29a, Certifier (Check only one)	1 <mark>⊠ Certifyin</mark> 2☐ Medic <i>a</i> l E	g Physician: To the be examiner: On the bas and manne	is of examina	wledge, death	occurred vestigation,	at the tim	ne, date an pinion, deat	d place, a	and due to the ed at the time,	cause(s	) and m	anner as st and due to	ated. the cause(	(s)
To the within To the comple	Me	29b. Signature and t	1 mile	MI	)		D6	License						d (Month, E	,	9
		Satyam Sh	ah, MD	who completed cause 1500 For	est Gl	en Roa	d Si	lver	Spri	ng,	MD 201	0				
Sta Registi		31. Date filed (Month		009 Center	ristrar's Sign	par	43									

DHMH 17 Rev 1/2001

Physicia /Medic Examin	а
Funeral	

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hipry or other traumatic event, If a Modical Evanter must be redified at any hipry or other traumatic event, If a Modical Evanter must be redified at once. Baltimore, Maryland 21215-0036 Physician

/Medical

**Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

> Sta Registr

Registrar			Certific	cate of D	eath		R	eg. No.	UUD	Oid		
1. Decedent's Name (First, Middle, Last)							2. Date of Dea	th Day	Vasa	3. Time of Deat		
William A. Benson							Septemb		, 2009	9 4:0		
la. Facility Name (If not institution, give s	treet and num	ber)		4b. City, Town, or Location of Death					4c. County of Death			
Kline Hospice Hous				unt Air	-	24 Um			lerick			
700-01-2213	M 2□F	7. Age (In yrs. last b	Yrs. Mor		If Under 2 Hours	Min	8. Date of Birth (Month, Day March	(Year)	Con	nplace (State or For intry) ew York		
Usual Residence of Decedent  10a. State 10b. County		10c City Toy	wn or Location							10d. Inside City Lir		
Maryland Frederick			lerick				10d. Inside City Limit 1 ☑Yes 2 ☐ No					
Oe. Street and Number			10	f. Zip Code				I0g. Citizen	of What Cou	untry?		
5955 Quinn Orchard	Road			21704				United				
	2. Was Deced	dent Ever in U.S.	13. Was D	ecedent of His specify Cuban	panic Orig	gin? (Spec			Race - Amer	rican Indian,		
1 ☐ Never Married 2 🔀 Married	Armed For 1 XYes	2□No World				, Puerto F	lican, etc.)		Black, White	, etc.		
3 Widowed 4 Divorced	If Yes, Give Year or Da	e tes: War II	1 1 1	es 2.∏xNo	Specify:			Spe	wh	ite		
15. Decedent's Educ (Specify only highest grade	ation completed)	16	(Give kind o	Usual Occupat		of workin	g I		f Business/li	•		
Elementary/Secondary (0-12)	College (1-	4or 5+)	Capt	OT use retired)				New Yo		rtment		
17. Father's Name (First, Middle, Last)	4		Capt		18 Motho	r'e Name	(First, Middle,			.I Cilione		
Anthony Benasich							asovic					
19a. Informant's Name/Relationship (Тур	ne. Print)	10	b. Mailing Ada	dress (Street er	nd Numba	er or Rural	l Route Numbe	r. City or To	wn. State 7	ip Code) 2088		
iane I. Levy (Daug		l .		arr Spr								
20a. Method of Disposition	irecty	20h Place	of Disposition	(Name of	. !	Da	ate		on - City or T			
1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from S	tate cemet		or other place) uls	S	ept 2009	$9^{15}$ ,	German	ntown,	Maryland		
21. Signature of Funeral Service License	e N	1	Cemete 22. Nan	ry ne and Address	1		- 1	eral H	lome,			
1 th	1	M00689	) 10 E	ast Dee	er Pa	rk Di	rive, G	aithe	sburg	, MD 208		
resulting in death)	Due to (c									2 WKS		
that initiated events 📉 c.	Due to (d	or as a consequence	e of):									
resulting in death) Last	Due to (a	or as a consequence or as a consequence or as a consequence or pregnancy irth 2   Fetal dear ant at time of death	e of): e of): th 3 □ Ecto	opic pregnancy er (specify)					Date of deli Month	very Day Year		
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	Physic /Med		1. Decedent's Name (First, Middle, Last Henry A. Berline					2. Date of Dea Month 09	Day	009 Year	3. Time of Death 0445 M
The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	Exami		4a. Facility Name (If not institution, give 312 Canterfield Ro			4b. City, Town, or Annapol:	Location of Death		4c. Count		le1
	Funeral Director			x 7. Age (In yrs. last 75	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 02/09/	, Year) 1934	Cour	place (State or Foreign ntry) nington DC
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Anne Arus		Town or Lo			<u></u>		1	0d. Inside City Limits 1 Yes 2 No
	th with the 23a or 28a	al Direc	10e. Street and Number 312 Canterfield I		1	10f. Zip Code 21403		1	I0g. Citizen of	What Cour	ntry?
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ire Modical Examination mantle or office and once.	d by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2  Vietna If es, Give Year or Dates:	ım	I□Yes 2≹No	spanic Origin? (Spann, Mexican, Puerto Specify:	ecify Ye's or No- Rican, etc.)	Speci	· y ·	etc. Thite
21215-0036	filed within 72 h Hygiene. ither than "natu	Completed	15. Decedent's Edu (Specify only highest grad	College (1-4or 5+)	16a. Deced (Give life. I Presi		ation Juring most of worki )	ing	16b. Kind of E	Business/In Banki	•
Maryland	2 should be filed within and Mental Hygiene is marked other than '	To Be C	17. Father's Name (First, Middle, Last) Henry A. Berliner	:			18. Mother's Name Josephin			me)	
	and 2 sho lealth and m 27 is mo		19a. Informant's Name/Relationship (7) Margaret R. Berlir	ner Spouse	312	Canterfi	and Number or Rura	Annapoli	is,MD 2	1403	
Baltimore,	t. Pages 1 rtment of H rtant: If ite		20a. Method of Disposition  1	Removal from State Rock	cree Cree	sition (Name of natory or other plac k Cemete:	e) 9/15		20c. Location Vashing	•	
Bal	permit. Departr Importa any Inji		21. Signature of Funeral Service Licens  Oavid	1	H		Funeral H			dgely ofis,	MD 21401
1	Physician /Medical Examiner		23a. Part 1. Enter the Asease, or complete shock, or hear failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. ne cause on each line. a.  Due to (or as a conseque	pai		g, such as cardiac		rest,		Approximate Interval Between Onset and Death
30,		I Examiner	Sequentially list conditions, if any teach to him additionable cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b						2	
O. Box 68760,	eath certifi attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	eath 3	Ectopic pregnance	,			ate of delive	ery Day Year
σ.	uires that the de n signed by the Id be detached i	þ	Part II. Other significant conditions co	ntributing to death but not resulti	ing in the u	nderlying cause give	en in Part I.	23e. Did to	<b>S</b>	atribute to the	he cause of death?
of Vital Records,	idan: The law requir certificate has been s ector, page 2 should	Completed						24a. Was a autops perfor	sy	Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of 2 □ No
of Vit	Physiclan: r this certific ral director,	: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatier		4 LI Nursing Ho	*	ence 6 □Ot	1-7	(y)
Division	To the Hospital or Attending F within 24 hours after death.  To the Funeral Director; After completely filled in by the funera	Certification:	1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	(Month, Day, Year)  28e. Place of Injury - At hom building, etc. (Specify)	Injury	M 1 🗆	Yes 2 □No		treet and Num		al Route Number,
	the Hospital hin 24 hours a the Funeral in pletely filled	Medical (		sician: To the best of my knowl ner: On the basis of examinatio and manner stated.							
	To the within To the Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex C	Me	29b. Signature and title of certifier	milsuo		29c. Licenso	number 9838	2	29d. Date sign	20 C	Day, Year)
上	1041		30. Name and address of person who con STUAVT E. SE	DINICK MAD	anc	Resta	ate Rd.	Auna	apolis,	Md	. 21014
DH	Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Standard Sta	rar		32. Registrar's Signatur	B. 19	barke					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Thelma Helen Buffo 10:05 AM September 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Crofton Care & Rehab Crofton Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏝 F Days Months Hours July 13 1918 Pennsylvania Director 211-01-9059 91 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 No Gambrills Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1101 Top Ridge Court 21054 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify White If Yes, Give Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 721 h and Mental Hygiene. 7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesperson Clothing Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Vincent Carnevale Giovannia Tudini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a : If item 27 is Darnell Foster / Granddaughter 1101 Top Ridge Court, Gambrills, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 N Removal from State
4 Donation 5 Other (Specify) 9-14-2009 Calvary Cemetery Pittsburgh,Pennsylvania Signature of Funeral S 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Onset and Death Physician/ disease or condition resulting in death) -Pan Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) anding physician a use as the burial-Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year the i 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No I ∐ Yes Hospital or Attending Physician: 25. Was case referred to medical Division of Vital director, Be 26. Place of Death (Check only one) 1 Yes 2 200 Other ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? thin 24 hours after death.

the Funeral Director: After modeled filled in by the fun 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Powie MD

20715

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14300 CALLANT Fox Lane

		For State	State of M	aryland		rtment of H		lental Hyg	iene		31000
	Reg. No.									1119	-31332
Physicia	an	1. Decedent's Name (First, Middle, Las	,	~	ADMINI			2. Date of Deat Month	Day	Year	3. Time of Death
/Medic		MARY  4a. Facility Name (If not institution, give	M etroet and number		BARNET'		Location of Death	SEPTEMB	_	2009	12:05 A ^M
Examin	er	PRINCE GEORGE				CHEVERL			1	,	GEORGE"S
Funeral		5. Social Security Number 6. S	ex 7. A		ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birtl	hplace (State or Foreign
Director		220-12-2699	□M 2 <b>X</b> ]F   {	33	Yrs.	Months Days	Hours Min.	AUG 16	1926	MARY	untry) YLAND
pu >		Usual Residence of Decedent  10a. State 10b. County		100 City	, Town or Lo	nation .					10d. Inside City Limits
aryla shov	5	10a. State 10b. County									1 X Yes 2 □ No
the N	Director	MD PRINCE (	SEORGE'S	UPE	PER MAI			11	Og Citizen o	of What Co	untry?
bors after death with the Marylan ral" or items 23a or 28a-f show											
death ms 2:	Funeral	5207 SPRING DRIVE	12. Was Decedent		6. 13. y	Vas Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	14. R		rican Indian,
or ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces' 1 ☐ Yes 2 ▼☐ If Yes, Give	No		fYes, specify Cuba □Yes 2 🕱 No	n, Mexican, Puerto Specify:	Rican, etc.)		lack, White	e, etc. LACK
	d by	3√ Widowed 4 □ Divorced	Year or Dates:			Lifes 2 Aivo	эреспу.		Spec	נט אוע:	LACK
within 72 hours giene. r than "natural"; ine Medical Evi	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Deced (Give	lent's Usual Occupa kind of work done o DO NOT use retired	ation Juring most of work	ing	16b. Kind of	Business/I	Industry
within ene.	Ę.	Elementary/Secondary (0-12)	College (1-4or	5+)		ESTIC	)	í	PRIVAT	T	
filed Hygi other ent, I	a	12TH 17. Father's Name (First, Middle, Last)			DOM	23110	18. Mother's Nam				
ld be lental ked (	To B	WILLIAM HARRISON					ANNIE	WOOD			
shous and N s mai		19a. Informant's Name/Relationship (7	ype. Print)			g Address (Street a					Zip Code)
and 2 ealth n 27 i		INEZ R. CARROLL/	NIECE		800 1	NALLEY RO	AD LANDO				
pes 1 t of H or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	CE	emetery, cřen	sition (Name of natory or other place	9) !		20c. Location		
t. Pag tmen tant: jury		4 ☐ Donation 5 ☐ Other (Specify	)	RES		TION CEME		2/2009	CLINTO	)N,MAI	RYLAND
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ira M.		21. Sign are of Fundral Service Licen	see			Name and Addres  AND		J. B. JE			
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause	d the death							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition			ENAL F	AILURE					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):						
Lammer	_	Sequentially list conditions,	b	EUMON]							
ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	MENTIA	1						
execu n and al-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as								
cate be executed physician and the burial-transit	dical		d. DI	ABETES	S MELL	ITUS					
	Medi	IE ECNAL E.									
eath certificate attending processes	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	of pregnar	ncy death 3□	Ectopic pregnancy	,			Date of deli	
ie des the at ned fo	Physician/Me	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 ☐ Pregnant : 9 ☐ Unknown	at time of de	eath 5	Other (specify)				VIOTILIT	Day Year
hat the	윤	Part II. Other significant conditions of	ontributing to death I	out not resu	Iting in the un	ideriving cause give	en in Part I.	23e. Did tob	acco use co	ontribute to	the cause of death?
Attending Physician: The law requires that the death certifucate that the death certifucate has been signed by the attending by the funeral director, page 2 should be detached for use as	d by	DILATED ESOPH			Ť	, ,		1 □ Ye	s 💹 No	3 □ Pr	obably 4 Unknown
w req	ete	VALVULAR HEAR	T DISEASE					24a. Was ar	1 24	h Were au	ntopsy findings available
he la te has age 2	Completed	VIIIVOIMIK IIIIIK	I DIDLIIDL					autops perforn	y ned?	prior to death?	completion of cause of
an: Trifica	Be C	25. Was case referred to medical					26. Place of Deat	1 ☐ Yes 2		1 ∐ Yes	2 X No
nysica nis ce direc		examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 □Xnpat	ent 2 🗆 l	ER/Outpatien	t 3 DOA Othe	er: 4 🗆 Nursing Ho	ome 5 Reside	ence 6 🗆 C	Other (Spe	cify)
ing P	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury ay, Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe ho	w injury occ	urred	
ttend death ttor: /	cati	2 Accident investigation 3 Suicide 6 Could not be		i At h a			/es 2□No	006 1			
To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached it	Certification: To	4 ☐ Homicide determined	building, e	tc. (Specify	nie, iarm, stre	eet, factory, office		City or Town	reet and Nui 1, State)	nber or Hu	ıral Route Number,
spital nours neral			ysician: To the best								
he Ho in 24 I he Fu pletel	Medical	(Check only 2 Medical Exam	iner: On the basis and manner s	of examinat tated.	ion and/or in	estigation, in my o	oinion, death occur	red at the time, d	ate and plac	e, and due	to the cause(s)
vith com	Σ	29b. Signature and title of certifier	/ / 1			29c. License					h, Day, Year)
3	1		es les L				06698	4	7/	16/	2009
A		30. Name and address of person who of DHIRGHAM KSHASH					6 COLLEG	E PARK,M	ARYLA	ND 20	740
Sta Registra	_	31. Date filed (Month, Day, Year)	32. Regist								
		CPD I BY COOL	The second	1	//						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day September 22 **Physician** Warren Van Conway 5:57 a.M 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick College View Center Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F 005-36-7578 70 Vrs Oct. 25, 1938 Director Maine Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at Frederick Maryland Frederick by Funeral Director 1K Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ USA 21701 700 Tollhouse Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 57-77 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Magnote. Elementary/Secondary (0-12) College (1-4or 5+) United States Air Force Recruiter 12 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanley Max Conway 2 Eleanor Henninger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 862 Carneal Road, Lexington, Kentucky 40505 Pamela Norton/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State Smithsburg Crematory Sept.23,2009 Smithsburg, Maryland 4 ☐ Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 504 Main Street Myersville, MD 21773 Ricketts Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** eeling 145terolnt disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physlcian: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 2 🗆 No 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 No 1 ☐ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 → 10 Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records,

State Registrar

31. Date filed (Month, Day, Year) Registrar's Signature SEP 3 0 2009 DHMH 17 Rev 1/2001

shah

29b. Signature and title of certifier

Hemen

0

Thomas

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tohnson

29c. License number

29d. Date signed (Month, Day, Year)

Frederick MD 21702

7-09 FM) McCo State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 8:04PM Physician 2009 onald. Claycomb September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltmore Maryland Trauma-Univ. of If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Washington, DC 4-05-0555 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinant must be notified at 1 ☐Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number IISA 20904 3124 Gracefield Road, #107 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1942-46 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑No Specify: Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineering Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Sadie V. Phillis William Earl Claycomb ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 8728 Tryal Court, Montgomery Village, MD 20886 Donna C. Millard/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Sept. 2009 19 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 No subject fell out of bed 2 X Accident 9-10-2009 2200 p 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3124 Gracefield Rd, Silver Spring 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours at home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 325 S. Belmont St. York PA 17403 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 31. Date filed (Month, Day, Year)

162009

3001

32. Registrar's Signature

Records, P.O. Box 68760 of Vital Division Hospital or Attending within 24 hours after death. To the Funeral Director: completely

> ior W State

> Registrar

29b. Signature and title of certified

2225E De

ause of death (Item 23a) (Type, Print)

29c. License number P 0 0 2 9 5 7/

tense thuy, crofton, MD 21114

DHMH 17 Rev 1/2001

		State	te of Maryland / I	Department of <i>Certificate of</i>			ene _{a. No.} Z. U U 9	1133
		Registrar  1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
Physicia /Medica		Norman Emanuel Cave					2c 15,2009	10:55 P.M
Examine		4a. Facility Name (If not institution, give street a	ŕ	4b. City, Town,	or Location of Death		4c. County of Death	
		Prince George's Hos			erly If Under 24 Hrs.	O Data of Bloth	Prince Geo	orge's  place (State or Foreign
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last bii	Yrs. Months Days		8. Date of Birth (Month, Day,		intry)
		213-12-1592 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Page 18 Pa	89			06/20/19	920 Fair	mount Agts.
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within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show he hadeal Everina must be notified at	'n.	Arr	s Decedent Ever in U.S. ned Forces? <b>X</b> es 2  No	13. Was Decedent of If Yes, specify Cul	ban, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	, etc.
Irs aff	by	If Y	es, Give 41 – 45 ar or Dates:	1 □Yes 2 No	Specify:		Opecny.	frican- merican
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perion. rages Department of Important: If It any Injury or o		23a. Part1. Enter the disease, or complications	2 rall	H.S.Wa	ess of Facility Shington (	& Sons Co	.,Inc.	
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in 24 hour the Funera	Medical (	(Check only 2 Medical Examiner: O	To the best of my knowledg in the basis of examination and id manner stated.	nd/or investigation, in my	opinion, death occur	rred at the time, da	te and place, and due	to the cause(s)
Mort Con Con	Σ	29b. Signature and title of certifier  A. A.	luas MI	_	45341		entember	-
va		30. Name and address of person who complete	krus Pi	(Type, Print)  (INCE G	eorge 16	spital	September Cheverl	4,41)
Stat	e	31. Date filed (Month, Day, Year)  CED 1 8 2009	32. Registrar's Signature	les .	,	,	20	785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician DOYLE DEAN DILGARD 200 Siember /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. ty of Death **Examiner** 1 Ca Under 1 Year | If Under 2 8. Date of Birth 4 (Manth, Pay, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral Months Days OHTO" 1 **X**M 2 □ F Hours Min 291-12-9662 85 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at MD. CHARLES WALDORF 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1206 ADDISON COURT U.S.A. 20602 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 KiYes 2 □ No If Yes, Give USAF Year or Dates: (RET.) Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ∐Yes 2 ∭Wo Specify Specify: WHITE Be Completed by 3 Nidowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) AERIAL ENGINEER U.S.A.F.9RET.) 12 marked other Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLARENCE H.DILGARD HAZEL FAY ALLENBAUGH ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRACE THRIFT-DAUGHTER 29804 DONNA DR. MECHANICSVILLE, MD. 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State | Certificity, Cremation | State | Cremation | State | Cremation | State | Cremation | State | Cremation | State | Cremation | State | Cremation | State | Cremation | State | Cremation | State | Cremation | Cremation | State | Cremation | Cremation | State | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation | Cremation rtment of 2. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Franeral Service Licenses M00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NUTRITION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. COLON CANCER and as the burial-tra Due to (or as a consequence of): P.O. Box 68760, attending physician Deficile Colitis ostridum Physician/Medical nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy for Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 certificate 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signatore and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)

9*

State Registrar

DHMH 17 Rev 1/2001

Ave PO BOX 1070

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 4 2009 11:15P JAMES OWEN DRUMMOND SEPT. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CHARLES GENESIS WALDORF CENTER WALDORF Birthplace (State or Foreign Country) 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthdav) Min Months Days Hours XXXM 2□ F WASH., DC DEC.8,1933 75 579-48-1729 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 ☐Yes 2 No CHARLES COBB ISLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12082 NEALE SOUND DRIVE 20625 U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 50 - 56 1 Never Married Married 1 ☐Yes 2 No Specify $^{\textit{Specify:}}\, \textbf{WHITE}$ 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DISTRICT MANAGER TELEPHONE COMPANY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LUCY LEONA LAPLANT OWEN MCKINLEY DRUMMOND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12082 NEALE SOUND DR., COBB ISLAND, MD 20625 MARY LOU DRUMMOND/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 25,2009 METRO.CREMATORY ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) **FEMALE**: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? onditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

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Important: If it
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Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Its Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

burial-tran physician the burial nding pluse as t director.

Division of Vital Records, P.O. Box 68760,

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Hospital or Attending Physician: The law requires that the death certificate be executed n 24 hours after death. le Funeral Director: Af pletely filled in by the fur Medical within 24 hor To the Fune completely f

DHMH 17 Rev 1/2001

State Registrar

Was case referred to medical 1 Yes 2 No Manner of Death 1 Natural

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

OUD LINE CEUTER WALDONG

28d. Describe how injury occurred

🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

of person who completed cause of death (Item 23a) (Type, Print) 10

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day,

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician September 14 2009 12:45 PM Dowell Evelyn Jean Hall /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Owings Calvert 2955 Chaneyville Road 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07–19–1926 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 83 Director 216-24-3966 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinant has notified at 1 ∐Yes 2 🙀 No Director MD Calvert Owings 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20736 USA 2955 Chaneyville Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 2 Specify: 3 X Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelvn Rebecca Hutchins William 4 1 Hall Manning 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2905 Chaneyville Road, Owings, MD 20736 Judith D. Leavitt, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Harmony Cemetery 09-17-2009 Owings, MD 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infined ate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for se'n consequence offiattending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 **2**9Vo 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending PI within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

32. Registrars Signature

BART

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 7. Physician/ 2009 Henrietta Donaldson 10:45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death South River Health & Rehabilitation Anne Arundel Edgewater Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 V Hours Min. (Month, Day, Year) 7-28-1929 Country) Marvland Director 579-38-5846 80 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland Anne Arundel Harwood 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 239 Funeral 558 Harwood Road 20776 USA should be filed within 72 hours after death w and Mental Hygiene. is marked other than "natural", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. White Specify: 3 😾 Widowed 4 🗆 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin W. Greenwell Mallie Shifflett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 558 Harwood Rd., Harwood, MD 20776 George E. Donaldson, III/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State any injury or Kalas Crematory 9/10/09 Edgewater, MD 4 Donation 5 Other (Specify) 21. Signature of Juneral Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on sect line. Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 ding p IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 month 1 Yes 2 No Month Day Pregnant at time of death Unknown signed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy 1 Yes 2 No 1 Yes director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA After this Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending ■ Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Med val Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cyptong Nurse Pranticiper: To the control my knowledge, seek occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature, and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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WASH HINGTON RD, ENGENATER, MD MITUL

State Registrar 31. Date filed (Month, Day, Year,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician DOUGLAS DILLARD 5:00 AM WILLIAM SZUTZEND EK 15 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE DOCTORS COMMUNITY HOSPITAL LANHAM Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 □ F 81 040-60-1742 WASHINGTON, DC 2-8-1927 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the March Experiment must be notified at once. 10a, State 1 XYes 2 No Director PRINCE GEORGE LANHAM MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20706 9957 GOOD LUCK RD Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1 Never Married 2 Married 1 ∐Yes 2√ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. BLACK þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELSIE MONROE ည WILLIAM DOUGLAS SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9957 GOOD LUCK RD #T4 LANHAM, MD 20706 GWENDOLYN PHELPS/NIECE Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-17-2009 RIVERDALE, MD RIVERDALE CREMATORY 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List: nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of) Heari Jevere Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown tate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown Be Completed bstructive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 Inpatient 1∐ Yes ₽ No 2 ER/Outpatient 3 DOA Certification: To funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation n 24 hours after death.

e Funeral Director; Aft bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 hou

To the Fune

completely fi (Check only and manner stated the 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier MDD 60611 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 GOOD LUCK RUAD LANHAM, MO 20707 M. S. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	ate of Maryland / D	epartment of F Certificate of I			Jiene eg. No. 🎾 🍴 🕻	31343
	Physicia	an	1. Decedent's Name (First, Middle, Last) Sara Elvo	ove			2. Date of Deat Sep ^{oeth} emb	beray8, 2009	3. Time of Death 4:25 AM M
1	/Medic Examin	al er	4a. Facility Name (If not institution, give stree Arden Courts Assisted	et and number) Living	4b. City, Town, or Silver	Location of Death Spring		4c. County of Dear	omery
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	2 XF 7. Age (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 6,	(Year) Co	thplace (State or Foreign ountry) KY
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location	<del></del>			10d. Inside City Limits
	e Mary Ba-f sh Liffi d	ctor	MD Montgomer	y Silver	Spring				1X Yes 2 □ No
	with the	Funeral Director	10e. Street and Number 2505 Musgrove Road		10f. Zip Code 209	24		Og. Citizen of What Co	
	death	nera		Vas Decedent Ever in U.S.	13. Was Decedent of H			United Stat	erican Indian,
9000	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show Jone Examinat must be rediffed at	5	1 X Never Married 2 Married 1	□Yes 2 X No fYes, Give ear or Dates:	1 □Yes 2 No	Specify:		Black, White	White
15-(	in 72 h n "natu	Completed	15. Decedent's Educatio (Specify only highest grade cor	npleted) (	Decedent's Usual Occup Give kind of work done of life. DO NOT use retired	during most of work		16b. Kind of Business	/Industry
212	ed with ygiene ier thai	Com	12	College (1-4or 5+)	lerk			Federal Go	overnment
/land	uld be file Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last)  Jacob Elvove			18. Mother's Name Simma	e (First, Middle, I	Maiden Surname)	
, Mar	and 2 sho ealth and n 27 Is ma		19a. Informant's Name/Relationship (Type. F Jay Elvove - Nephew	960	Mailing Address (Street 02 Sutherla	nd Road S		-	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examiner must be rediffed a once.		20a. Method of Disposition  1 汉 Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	val from State 20b. Place of I cemetery  Mt Leb	Disposition (Name of crematory or other place anon Cemete	e) 9/		20c. Location - City or Adelphi, MI	
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4			shock, or fleart failure. List only one ca			g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Senile I	Dementia n:				10 years
	Examiner		Sequentially list conditions. b. —	Osteopor	osis				20 years
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter un derying Cause (Disease or injury that initiated events	Due to (or as a consequence of	·):				
68760,	rificate be executed ng physician and as the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as a consequence of	·):				
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Vital	Physician: r this certifica ral director, p	BeC	25. Was case referred to medical examiner?	ital	104	26. Place of Deat	h (Check only or	ne)	
of	Physical direction	2	1 ☐ Yes 2 ☐ No Hospi  27. Mapner of Death 2.	8a. Date of Injury 28b. Ti		4 L Nursing H		ence 6 \textsquare Other (Special own)	ecifyAssisted Living
sion	Attending ir death. ector: After by the funer	ation	1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Inj		? Yes 2 □No			
Divis	or Atta after de Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	<ol> <li>Place of Injury - At home, farr building, etc. (Specify)</li> </ol>	m, street, factory, office		28f. Location (S City or Town	treet and Number or R n, State)	ural Route Number,
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	3		· Jane 10-		D432				er 10, 2009
			30. Name and address of person who completed and Arumstrong MD 14	ered cause of death (Item 23a) (1 +201 Laurel Par	k Drive Sui	te 102 La	urel MD	20707	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 6 2009	32. Registrar's Signature	all				

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			State Registrar				C	ertific	ate of	Death			Reg. N	o.C.U	45	3   3 4 4
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4	Funeral Director		5. Social Security Number 242-10-0153	6. Sex	M 2 🔼 F	,	n yrs. last birthd	Mont	der 1 Year	If Under	24 Hrs. Min.	8. Date of Bi (Month, Da April	rth ay, Yea	7916	9. Birthp Coun	lace (State or Foreign try) th Carolin
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	the Ma 28a-f s notified	Director	Maryland Mon	tgon	nery		Rock	ville 10f.	Zip Code		······································		10g. C	1 ☐ Yes 2 🗷 No  Citizen of What Country?		
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Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service					Fran 500	and Addr Cis J Unive	ess of Facili • Col •rsity	lins Blv	Funera	al H Sil	ome ver	Inc. Sprin	g, MD 2090
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O. Box 687	the death certificate the attending phys ched for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ∐Yes 2 ☑No 9 ∐Unknown	23	1 Live	gnant at tim	Fetal death	3 🗆 Ectop 5 🗆 Other		су					ate of delive	ery Day Year
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Vita	Physician; Th this certificate al director, pag	Be	25. Was case referred to medical examiner?		spital:				Ot	hor:		(Check only				
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Division of Vital Records,	To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral	27. Manner of Death   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes   2   No   28c. Place of Injury - At home, farm, street, factory, office   28f. Location (S. City or Town)					(Street	and Numi		al Route Number,						
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	5		20 Name and address of person	10	<u> </u>		/II 00> /T-	- D-1 0	700	600	~0		100	tem	25 1	4,2009

State Registrar

Padmaja Bandi, MD

31. Date filed (Month, Day, Year) SEP 16 2009

DHMH 17 Rev 1/2001

32. Registrar's Signature

18101 Prince Philip Drive, Olney, MD 20832

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		F	legistrar	ificate of L	Jean	2. Date of Death	g. No.	3. Time of Death				
Mar	Physicia dical Exami		1. Decedent's Name (First, Middle,Last)			Month September		0218 hrs				
WIC (	ilicai Examii		Emmanuel Anthony Franc  4a. Facility Name (if not institution, give street and number)	:1S	. City, Town, or Location o		4c. County of Death					
			20131 Welbeck Way		Montgomery Village		Montgomery					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year If Unde		h(MM/DD/YYYY) 9. Bir Foreig	thplace (State or				
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		- }	Usual Residence of Decedent									
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	aryland 8a-f show at once.	ᅵ	Md. Montgomery Mon	itgomer	miery viriage							
1	Aaryla 28a-f	Director	10e. Street and Number		10f. Zip Code	10	10g. Citizen of What Country?					
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)	h with	Funeral	11. Marital Status 1 XNever Married 2 Married Armed Forces?	<ol> <li>13. Was If Yes</li> </ol>	Decedent of Hispanic Orig s, specify Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	- 14. Race - Amer White, etc.	ican Indian, Black,				
,	r deat or ito	Fun	1 Yes 2 X No	40,	res 2 X No specify:		Specify: b	lack				
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	2121 ould be fil d Mental I s marked iic event,	ပ္	19a. Informant's Name/Relationship (Type, Print )	1								
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Marcia Brown Morris /Mothe	<u>er 20</u> 1	131 Welbec ion (Name of cemetery,	k Terr. M	ontgomery 20c. Location - City o	Village M				
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	Baltimore, permit Pages I an Department of He Important: If ite				National							
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			23a. Part I. Enter the disease, or complications that caused the death.	Do not enter the	1 Kennedy	St., NW Wa	Shington est. shock, or heart	DC 20011				
	Physician Medical		failure. List only one cause on each line.			,		Between Onset and Death				
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	lor A after I Direct din b	Certification:	3 X Suicide 6 Could not be determined (Specify) Othe	ome, farm, stree er- home		Mon Ego	State 20104 We	Rural Route Number, City ELDECK Ter. Se, MD				
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	Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical	one) 2 Medical Examiner: On the basis of examination a	and/or investigat	tion, in my opinion, death o	occurred at the time, date	e and place, and due to	the cause(s)				
	To To com	Meo	29b. Signature and title of certifier		29c. License numbe		29d. Date signed (I					
1			hall and a	D	O.C.M.E.		September 22,	2009				
			30. Name and address of person who completes cause of death (Item	n 23a)								
10	-1		Russell Alexander MD. Assistant Medical Exan	miner 111	Penn Street, Baltin	ore, MD 21201						
Ė		tate		are de								
	Regis					D.C. L.C.						

DHMH 17 Rev 1/2001 OCME 2006 OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) SEP **Physician** 5:00 RM 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall 8. Date of Birth Month, Day, . Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex/ **Funeral** Months Davs Hours 7-42-942 79 Georgia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23 a or 28a-f show any injury or other traumatic event, Ite Medical Examinar must be redified at appear. Once. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County 1 ☐ Yes 2 X No Director MD Calvert Lusby 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20657 United States 11535 Buckskin Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mres 2 □ No If Yes, Give Year or Dates: Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Large Appliance Repair General Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Louise Justice David P. Gee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11535 Buckskin Court, Lusby, Maryland 20657 Janet Ann Gee (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Southern Mem Gardens 9/18/2009 Dunkirk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service-License P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC Physician ARRHYTHMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CONGESTIVE HEART Sequendary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 T Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by OBSTRUCTIVE 3 ☐ Probably 4 ☑ Unknown AIRWAY 1 ☐ Yes 2 ☐ No MRONIC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has but director, page 2 st autopsy 242 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩6 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0

State Registrar 31. Date filed (Month, Day, Year)

RAO

29b. Signature and title of certifier

32. Registrar's Signature B. parl

CALVERT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KODALI.

29c. License number

D67788

29d. Date signed (Morith, Day, Year) 9.15.2009

FAM. CARE CENTRE, SOLOMONS, MD 20688

09-07320 Leo Grisko

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

oo onoko		- For State Criticate of Death		teg. No.	100 3131
Physician/	1.	1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month	Day Year	3. Time of Death
Medical Examiner		Leo Grisko  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea		er 18, 2009 4c. County of De	
	4	44. Facility Name (if not institution, give steet and number)  11945 Bennett Road Cobb Island		Charles	
Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H		irth (MM/DD/YYYY) g.	Birthplace (State or eign
Director		174-24-2495   1X M 2 F   87 Yrs.   Months   Days   Hours   M	Jun.		Thy ylvania
<b>X</b>	-	Usual Residence of Decedent  10a State 10b, County 10c, City, Town or Location			10d. Inside City Limits
ow any	Ι.				1 Yes 2 X No
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uth the Maryland 23a or 28a-f sho notified at once		16945 Bennett Road 20625	ļ	U. S. A	A .
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Heath and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue		o- 14. Race - An White, etc	nerican Indian, Black,
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re, l s l and f Heal ff item		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	eptembe	20c. Location - City	y or Town, State
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Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traur	2	21. Signature of Funeral Service Licensee  M00641 5635 Washington	aymond	Funl.Ser	vice, P.A.
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	ac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
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F % F 2	Ĕ	29b. Signature and title of certifier 29c. License number			(Month, Day, Year)
		Mayaira Melfrell O.C.M.E.		September 1	J, 2009
5+11		30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, N	MD 21201		
Star	te	31. Date filed (Inchin Pan Yeer) 32. Registrar's Signature			
Registra	ar	SEP 3 0 2009 Kenne B. Jane			

### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** September 12, 2009 H. Hamm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital Rethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours X M 2 □ F 85 April 12, 1924 220-12-2763 **Director** Usual Residence of Decedent 10c. City. Town or Location 10b. County show d other than "natural", or items 23a or 28a-f shor event, the Medical Examiner must be notified at Director Kensington Maryland Montgomery 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 20895 11110 Valley View Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after. and Mental Hygiene. is marked other than "natural". or Ited 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specify: Specify: þ WWII 3 Nidowed 4 Divorced Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Heating & Air Conditioning Elementary/Secondary (0-12) College (1-4or 5+) Business 12 Owner & Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental William Robert Hamm Nona Spicer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trau once. 4311 Garrett Park Road, Silver Spring, MD 20906 Richard L. Trent/Administrator 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 19 Sept. 2009 1 Burial 2 □ Cremation 3 □ Removal from State Parklawn Memorial Park Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, Md 2090 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner Ascending Cholangitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown icate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 🖂 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? tamm, Barty 24a. Was an was autopsy performed? 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending Pl n 24 hours after death ne Funeral Director: After the 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) u by 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D66300 September 12, 2009 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 10

32. Registrar's Signature

1 0 .

Dr. Suj - y

31. Date filed (Month, Day, Year)

16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

West Virginia

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

Year

1 Yes 2 No

1:20 p M

DHMH 17 Rev 1/2001

State

Registrar

8600 Old Georgetown Road, Bethesda MD 20814

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 144 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE ANIVERSTY OF If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) Social Security Number Months Days 1 XM 2 ☐ F 68 216-40-6564 Maryland 01 - 21 - 1941Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 TyYes 2 □ No Hyattsville Prince Georges MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20785 USA 2610 Crest Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 □XNo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shellie Hall, Sr. Ella Hicks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 I 0 Crest Avenue 19a. Informant's Name/Relationship (Type. Print) Cecelia Hall 20785 Hyattsville, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem. Park | 09-23-2009 4 ☐ Donation 5 ☐ Other (Specify) Landover, MD Ralph Williams, II Funeral Service, P.A. 5202PrincetonsDelightDr., Bowie, MD20720 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a c in equence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Tes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy berformed' 2 No 1 Wes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Chec only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending 1 Tyes 2 🗌 No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

that the death certificate be executed and burial-tran physician the as nse for ned by the a o. ۵. signed t Records, page Vital After this c funeral dire o or Attending Division

**Physician** /Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural"

al Hygiene.

1 and 2 should be fill Health and Mental H em 27 is marked ott ther traumatic even

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permit. Pages 1 and Department of Health Important: If item 27 any injury or other th

**Physician** 

/Medical **Examiner** 

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Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours a er dea h.

To the Funeral Director: A completely filled in by the fi To the Hospital

State Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

and manner stated.

29c. License number

17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day, 09 Month 13 09 10:38p M Stanley Leroy Hill Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Laurel Regional Hospital Laurel 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day 7. Age (In yrs. last birthday) 5. Social Security Number **№** M 2 🗆 F Months 06/03/1950 59 Washington, 579-64-3098 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1√Yes 2 No Laurel Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20708 13005 Mistletoe Spring Rd. #717 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Xlo Specify Specify: Black 3 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mortgage Broker Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Christine Almeria Williams Stanley Leroy Hill Sr. 19a. Informant's Name/Relationship (Type. Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20708 Phyllis D Washington-Hill 13005 Mistletoe Spring Rd,#717, Laurel, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Riverdale, MD Riverdale Park 9/18/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal Mortuary Inc. 21. Signature of Funeral Service License 411 Kennedy St NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ruptured Abdominal Aortic Aneurysm Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dust to (or as a consequence of) Due to (or as a consequence of): yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

2

Completed

Be

MD

ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

within 72 hours after death

d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r

permit. Pages 1 and 2 st Department of Health an Important: if item 27 Is r any injury or other traur

Baltimore, Maryland 21215-0036

the burial-transit physician signed by the a d be detached for been si should l page 2 s certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p.

The law requires that the death certificate be executed

P.O. Box 68760,

of Vital Records,

Division

Examiner Physician/Medical þ Completed Be Certification: To 27. Manner of Death

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Hypothyroidism 25. Was case referred to medical examiner? Hospital: 1 Types 2 □ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA

1 Tes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

	29a. Certifier
	(Check on
l	one)
L	

Medical

1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

determined

29c. License number D1831

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Yea SEP 1 8 2009 State Registrar

28a. Date of Injury (Month, Day, Year)

7300 Van Dusen Rd., Laurel, MD 20707

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 320 0 Robert 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5. Social Security Number A Anna Medical Center If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours 108 M 2□ F Director MARYLAND 200 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location show Funeral Director Yes 2 No ral", or items 23a or 28a-f Examiner must be notified wate 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2103 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ∐Yes ZYNo If Yes, Give Year or Dates: Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Completed by Specify: Whit 3 Widowed 4 Divorced 'natural", other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) UNK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be item 27 Is marked o ျှ Katherine Annette 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rulal Route Number, City or Town, State, Zip Code) Edgewater Mary bord 21037
Date 20c. Location - City or Town, State 406 Beach Drive Katherine Annette 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 of = 10 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 9/14/09 Burnie 4 Donation 5 Other (Specify) Cremetery 20 21. Signature of Funeral Service License 22. Name and Address of Facility 12 Ridgely Ave Hardesty Funeral Home P.A. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician prematurit sevel e /Medical Due to (or as a consequer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and ibe detached for use as the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21XN0 1. Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: completely filled in by the 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addre s of person who completed cause of death (Item 23a) (Type, Print) JOE MOTPRIS 200

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical Marie C. Jenkins September 11, 2009 10:30 a 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Frederick

Prince Frederick

If Under 24 Hrs. Calvert County Nursing Center Calvert 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days Hours 1□M 2MF Director 100 February 15, 1909 MD 578-44-0563 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notifled at 1 ☐ Yes 2 No Director Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20639 USA 720 Ponds Wood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No Specify: Specify: þ 3 MWidowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) 6 Someone Else's Home Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Joseph Holland Annie Wills 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any InJury or other traum P.O. Box 403, Upper Marlboro, MD 20773 Gloria Mackall - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wards Mem. UMC Cem. | September 19, 2009 | Owings, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. Glady a. 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiovoscular dicense Atherosclenotic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-trans Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Dementia. Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 1 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifies 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 50653 urcera 9-16-2009. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - GYAN . C . SURBWA 3 Deale Road Deale State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760

Division or Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 15, 200 **Physician** 6 326 AM SHEILA JANIFER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S DOCTORS HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, JULY 15 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year) Days Hours 1 □ M 2 🗓 F Director 577-58-9795 1944 WASHINGTON, DC 65 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County or than "natural", or items 23a or 28a-f show 1X Yes 2 No Director PRINCE GEORGE'S COLLEGE PARK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 4711 BERWYN HOUSE ROAD # 101 20740 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2 X No Specify: BLACK 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOG_GROOMER 12TH PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN MARGARET HELMS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24349 ASTOR RACING COURT VALENCIA, CA TYRONE S. RICHARDS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)

Strinature of Fineral Privice Licensee RIVERDALE CREMATORY 9/18/2009 RIVERDALE, MARYLAND J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Infarction **Physician** MUCarcuial disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Renal Failure Encephalopathy Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Diabetes mellitus 24b. Were autopsy findings available prior to completion of cause of death? performed metabolic acidosis 1 ☐Yes 2 ☑No 1 ☐ Yes 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

requires that the death certificate be executed sician and burial-trans physician at the burial Box 68760 ò P.0. signed be det Division of Vital Records, Medical Certification: To funeral after death filled in by the within 24 hours a

To the Funeral C

completely filled 1 2 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 065909 8/16/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good Luck Rd., Lanham, Mis. 20706 asil mi) o 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

28a-f show

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygi Important; If item 27 is marked other

jury or other traumatic

Pages 1 and 2 should

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Sylvester Clifton Jackson, Sr. 14,2009 6:42 P. September /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1X M 2 ☐ F Director 213-38-2397 05/19/1942 Wash., D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director Y Yes 2 No Md. Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3047 Chester Grove Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, 1XIYes 2 □ No
If Yes, Give Year or Dates: 64-66 1 ☐ Never Married 2 ☐ Married African-1 ☐ Yes 2 ▼ No Specify: er than "natural", c Completed by 3 Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Letter CArrier 12th Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifton Eugene Jackson ၉ Gladys B. Bell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other troones. Sylvester C. Jackson/Son 14812 Tongue Ave., Bowie, Maryland 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet's. Cem. 09/23/09 Cheltenham, Maryland 21. Signature of Funeral Service Licenses H.S. Washington & Sons Co., Inc. Harr. 4925 Burroughs Ave., N.E., Wash., D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Coronary Artery Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter conditioning Cause (Disease or injury that in its and cause). Examiner Due to (or as a consequence of): the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy certificate 1 ☐ Yes 27 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 SInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 24 hours a 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one)

The law requires that the death certificate be executed 68760, Ö σ. Records, Vital Physician: o is or Attending P safter death. I Director: After Division Hospital

within 72 hours after

filed withir Hygiene.

1 and 2 should be Health and Mental

Maryland

Itimore,

31. Date filed (Month, Day State Registrar

29b. Signature and title of certifie

29c, License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0057032

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) erson who completed cause of death (Item 23a) (Type, Print)
Kun Kunian, 6410 Rockledge Drive#200, Bethesda, Maryland

32. Registrar's Sign

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year **Physician** Sept 14, Hester Maud Kessler 8:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince George's Clinton Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** Days Min. Months Hours 1 □ M 2 Yrs. Director 011 14 1923 93 Jan 13. 1916 Nova Scotia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State items 23a or 28a-f shower interest be reconsisted at 1 ☐Yes 2 ☐ No XX Directo MD Prince George's Clinton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Alan Drive 5907 20735 United States Funeral death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or iten any or other traumafte event, IT as Mealfoal Examinatury or other traumafte event, IT as Mealfoal Examinatury. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XX Specify. Completed by Specify: White 3 ¥ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Manager High's Dairy Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Arnold Hardy Agnes Maud Freeman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Berhel (Daughter) 1025 Albert Road, Wind Gap, Pa 18091 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1 Department of H Important: If ite any Injury or ot XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wind Gap Cemetery Sept 19,2009 Penargyl , PA 21. Signatura Funeral Se the lightsee 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d moo257 Alexandria Ferry Road, Clinton, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration **Physician** 44 known disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnency 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Who 3 🗆 Ectopic pregnancy Day 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð tract intectes 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 sl autopsy performe 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, t

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

M. D.

12150 anapolismond smite B312 Glandle, MD 20769. ROIMAN FARAHIFAR M. Q

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

SEP 16 2009



29c. License number

D43446

29d. Date signed (Month, Day, Year)

9.14.09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Day September Da **Physician** 3:00 A M SELENA GERTRUDE KNIGHT 11 7009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7513 Millrace Rd. Capitol Heights Prince Georges If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 VA 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb 25 5. Social Security Numbe **Funeral** Months Days Hours 1 □ M 2 🕱 F 84 579-32-5761 **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director MD Prince Georges Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 7513 Millrace Rd. 20743 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 [X]
If Yes, Give
Year or Dates: 2[XNo 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify <u>م</u> Specify. 3 Widowed 4 Divorced "natural" Black Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, Pages 1 and 2 should be filed withir ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Security Processor 10th Bureau of Engraving 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked of traumatic even Walter Johnson 2 Estelle Foy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Horace Knight - Husband permit. Pages 1 and Department of Healtl Important: If item 27 any injury or other tonce. 7513 Millrace Rd. Capitol Heights, Md. 20743 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-30-2009 Arlington National Arlington, VA. 21. Signature of Fungral Service Licensee 22. Name and Address of Eacility
Marshall's Funeral Home of Maryland Melbrine 4308 Suitland Rd. Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as consequence f) disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami the burial-tran Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical SBS attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2 □No ed by the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? of Vital Records, \$ should be 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

DHMH 17 Rev 1/200

29b. Signature and title of certifier

DED COUNT ROAD RANCEllsterm MD Burtan 5401 32 Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

leberah

29c. License number 1445931 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 23.2001 2.20 PM Irene Lello 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANNE ARUNDEL BALTIMORE WASHINGTON MESSIGH CENTER SURNIE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 23, 1914 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 M 2 XF Yrs. Estonia 216-30-8680 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Anne Arundel Odenton 1 ☐ Yes 2 🛣 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1333 Center Street 21113 Estonia Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper National Plastics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernst Hein Olga Teterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Viia Erwin Daughter 1333 Center Street Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Epiphany Cemetery 09/28/09 Odenton, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licens 851 Annapolis Road Dales Hardesty Funeral Home P.A. Gambrills, MD 21054 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BNGESTIVE FARCURE disease or condition resulting in death) as a consequence of): Due to (or PAZTENSON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) 23d. Date of delivery Month Day Year se contribute to the cause of death? □ No 3 □ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 6 ☐Other (Specify) y occurred

Examiner ettending physicien and for use as the burial-transit sete has been signed I page 2 should be det certificate SIU! After this death.

**Physician** 

/Medical

Physician/Medical Examiner Be Completed by ဥ Medicai Certification: Director:

Physician

/Medical

Examiner

Director

Be Completed by Funeral

ဥ

**Funeral** 

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depentment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-f ehow empiry or other treumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after dea To the Funerei Director completely filled in by th

Cause (Disease or injury that initiated events resulting in death) Last	c	quence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 modths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of o 9 □ Unknown	el death 3 Ectopic	c pregnancy (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions co	ontributing to death but not re-	sulting in the underlyin	g cause given in Part I.	23e. Did tobacco	use contribute to the cause of death	
				24a. Was an autopsy performed 1 Yes 2 No		
25. Was case referred to medical examiner?				th (Check only one)		
1 ☐ Yes 2 € No	Hospital: 1 Inpatient 2 □	ER/Outpatient 3	DOA Other: 4 Nursing H	ome 5 Residence	6 ☐Other (Specify)	
27. Manuer of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how inju	ury occurred	
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fac	28f. Location (Street a City or Town, Stat	<ol> <li>Location (Street and Number or Rural Route Number, City or Town, State)</li> </ol>		
	ysician: To the best of my kn niner: On the basis of examin and manner stated.				s) and manner as stated. nd ptace, and due to the cause(s)	
29b. Signature and title of certifier			29c. License number	29d. D	ate signed (Month, Day, Year)	

ed cause of death (Item 23a) (Type, Print)

HOE

201

State Registrar 30. Name and address of person who comp

Inice Glan Burnie Mi)

09-07425 David Lambert

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		For State		Certificate d	of Death		Re	g. <b>N</b> o.	
Physiciar Medical Examin	1/ 1	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month Day Year						3 Time of Death	
	4	4a. Facility Name (if not institution, give street and number)  Calvert Memorial Hospital  4b. City, Town, or Location of Dea						4c. County of I	Death
Funeral Director		5. Social Security Number 6. Social Security Number 182–34–6567	7. Age (In	yrs. last birthday)	If Under 1 Yea Months Day		8. Date of Birth. 03/13/	Į.	9. Birthplace (State or Foreign Country) PA
n with	eral Director	Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usual Residence of Decedent   Usua	nt Road		te Beach 10f. Zip Code 207	ispanic Origin? (	Specify Yes or No	U.S. 14. Race - White,	A • American Indian, Black,
2 hours after "natural",	mpleted by Fun	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	1 X Yes 2 1 1 Yes, Give Yeer 196 or Dates:  nly highest grade complet  College (1-4 or 5+)	No 1-65 1 1 16a. Deced during		o specify: ation (Give kind e. DO NOT use	of work done		white ness/Industry rtation co.
21215-0036 hould be filed within 7 ad Mental Hygiene. is marked other than itic event, the Medica	a	17. Father's Name (First, Middle, Last $Gilbert$ Last 19a. Informant's Name/Relationship (	ımbert			Ver	na Mae or Rural Route Nur	Cowling	State, Zip Code)
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic.	+	Patricia Lambert  20a. Method of Disposition  1	Removal from State	crematory or Chesapea	other place) Ake Highl Name and Addres 325 Mt. H	ands 0	9/26/2009 ausch Fur Lane, Ow	Port R neral Hom ings, MD	20736
Physician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approximate Interval Between Onset and Death  Death							
ecuted and - transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque						
760, cate be ex physiciar he burial	Physician/I	UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknow  Part II. Other significant conditions	9 OHKHOWH	of pregnancy  2  e of death  5	Fetal death 3 Other (Specify)	Ectopic pre	23e. Did		Day Year
Division of Vital Records, P.O tal or Attending Physician: The law requires that t rs after death.  "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac	Completed by				26 Pla	ice of Death (Ch	24a. Was auto perfi 1 Yes	s an 24b. V	Probably 4 V Unknown  Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No
ion of Vital Rec tending Physician: The eath. for: After this certificate the funeral director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	2 ER/Outpati 28b. Time	of Injury 28c. Ir	Tour	ursing Home 5	Residence 6 how injury occurre	Other:
Division of Vital Records, P.O. Box 683 within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as I	ledical Certification:	2 Accident Investiga 3 Suicide 6 Could not 4 Homicide determin 29a. Certifier (Check only one) 2 Medical Examin	ot be 28e. Place of Injury	nowledge, death o	ccurred at the time,	date and place.	or Town,	State)  use(s) and manner	ar or Rural Route Number, City as stated. ue to the cause(s)
F × F S	Me	29b. Signature and title of certifier  A Lun Bra  30. Name and address of person wh	melf, MD	th (Item 23a)		ense number C.M.E.		29d. Date signo	ed (Month, Day, Year)
	ate		Assistant Medical E	xaminer 11	1 Penn Street,	, Baltimore,	MD 21201		
Regist	rar	V2. V02	MAD JOHN	1671					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death Date of Death 1. Decedent's Name (First, Middle, Last) 1220 Day Year Month PM **Physician** 2000 Bik 2 -0 ne /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Ho spite Baltimore pealt If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Months Days 1 □ M 2 🖔 F 89 1920 China Feb. 8, 217-06-3987 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10d Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No MD Gaithersburg Director Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20878 United States 18 Leatherleaf Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛱 No Asian Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Exports Office Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kiu Luk Tin Po Lo ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18 Leatherleaf Court Gaithersburg, MD 20878 David K. Lee (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sept. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD Gate of Heaven Cem. 2009 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licentary 22. Name and Address of Facility DeVol Funeral Home MOIII6 Gaithersburg, MD 20877 10 East Deer Park Dr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Se psis **Physician** /Medical Due to (or as a consequence of): Examiner Prenmaria Sequentially list conditions, if any, leading to immediate cause. Enter Underly Cause (Disease or injury that initiated events resulting in death) Last Examiner Ventilater Depo Resp. rator for use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 🕱 No 5 ☐ Other (specify) 4□Pregnant at time of death 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No Nephrolithiesir 25. Was case referred to medical examiner? 1∐ Yes 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient ပ 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury 5 Pending investigation Natural Natural 1 ☐ Yes 2 ☐ No М 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 death.

Baltimore, Maryland 21215-0036

and cate has been signed by the attending physician page 2 should be detached for use as the buria or Attending Physician: this After Hospital

Certification:

within 24 hours after death To the Funeral Director:

To the

State

29b. Signature and title of certifie

16

29c. License number 61882

St. Baltimore

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 09-14.2009

MO 21230

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

601 S. Charles

31. Date filed (Month, Day, Year) SEP

4 Homicide

29a. Certifier (Check only

32. Registrar's Signature

			For State Registrar	State of Maryl		artment of I r <i>tificate of</i>			iene eg. No.	31350		
	Physici /Medic		Decedent's Name (First, Middle, Last Yun-Hua Lee	)				Date of Death     Month				
	Examin Funeral		4a. Facility Name (If not institution, give Suburban Hospita 5. Social Security Number 6. Se	1.1 (7. Age (ln)	yrs. last birthday) Yrs.	4b. City, Town, of Bethesd If Under 1 Year Months Days	a If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) C	omery rthplace (State or Foreign Country)		
	Show show	or	Usual Residence of Decedent  10a. State  10b. County	10c.	. City, Town or Lo			Aug. 13	, 1926	China  10d. Inside City Limits  1%□Yes 2□No		
re, Maryland 21215	th with the M 23a or 28a-f	al Director	Maryland   Montgo	mery Ga	aithersb	10f. Zip Code	878	10	Og. Citizen of What C			
	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show ofical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I fYes, specify Cub 1 □Yes 2X No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi			
	within 72 ene. than "nai	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed)  College (1-4or 5+)	(Give life. L	dent's Usual Occup kind of work done DO NOT use retire tal Work	during most of workir d)	ng	U.S. Post Service			
	2 should be filed and Mental Hygi Is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Si-Li Lee		100	COL WOLK	18. Mother's Name Choi-Fur	, ,	faiden Surname)			
	1 and 2 sh Health and iem 27 is m		19a. Informant's Name/Relationship (Tywilliam W. Lee/So 20a. Method of Disposition	n	606	Pheasant	Street, G	Saithers		20878		
	it. Pa rtmer rtant:		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licens			sition (Name of natory or other pla Memoria	; 20	ot. 20 009	Rockville	, Maryland		
Ä	permi Depa Impo any In	fr 00	23. Signature of Funeral Service Licensee  22. Name and Address of Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between									
	Physician /Medical Examiner	L	Immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Anoxic Brain Injury  Due to (or as a consequence of):  Aortic Insufficiency months								
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sufficie	ncy				months		
Box	death cerl e attendin d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1	etal death 3	Ectopic pregnand	гу		23d. Date of d Month	elivery Day Year		
ords, P.	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  within 14 hours after death. completely filled in by the funeral director, page 2 should be detached to the completely filled in by the funeral director, page 2 should be detached to the completely filled in by the funeral director, page 2 should be detached to the completely filled in by the funeral director, page 2 should be detached to the completely filled in by the funeral director, page 2 should be detached to the completely filled in by the funeral director, page 2 should be detached to the completely filled in by the funeral director, page 3 should be detached to the completely filled in by the funeral director, page 3 should be detached to the completely filled in by the funeral director.	Ď	Part II. Other significant conditions con	ntributing to death but not	resulting in the ur	nderlying cause giv	en in Part I.			to the cause of death?  Probably 4 12 Unknown		
Division of Vital Records,	To the Hospital or Attending Physician: The law requir within 24 hours after death.  To the Funeral Director. After this certificate has been s completely filled in by the funeral director, page 2 should	Completed	25. Was case referred to medical					24a. Was ar autops perform 1 🗆 Yes 2	y prior to ned? death? ! 🖳 No 1 🗆 Ye	autopsy findings available completion of cause of		
>	ysicia s cert directo	To Be	examiner?	Hospital: T Inpatient 2	□ SR/Outpation	t 3 DOA Oth	26. Place of Death		e) nce 6 ⊡Other <i>(Sp</i>	3.00		
sion of	ending Physath.		27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year	28b. Time of	28c. Inju Wor			w injury occurred	ecity)		
Divi	pital or Att ours after d eral Direct filled in by	Il Certification:	3 Suicide 4 Homicide  6 Could not be determined				, State)					
	n 24 h	Medical		ner: On the basis of exam and manner stated.	nination and/or in	vestigation, in my	opinion, death occurre	ed at the time, da	ate and place, and du	as stated. ue to the cause(s)		
	25	¥	29b. Signature end time of certifier	^		29c. Licens	6 2 2 8 3	29	9 12 0	nth, Day, Year)		
			30. Name and address of person who co Keith Horvath, MD				d, Betheso	da, MD 2	0814			
	Sta Registra		31. Date filed (Month, Day, Year) SEP 16 2000		gnature frau	res .						

DHMH 17 Rev 1/2001

09-07151 Jason Liser

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 31361

		- For State Registrar		Cer	rtificate c	of Death					eg. No.		
Physicia edical Exami	an/ ner	1. Decedent's Name (First, Midd Jason	n Andrew	Myers Li	iser					Date of Dea Month Septembe	e of Death th Day year ytember 13, 2009  4c. County of Death		
		4a. Facility Name (if not institution Prince Georges Hosp		d number)		4b. City, Tov Chever		cation of I	Death		Prince George's		
Funeral Director		5. Social Security Number 076-62-3334	6. Sex	7. Age (In yrs. I	32	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi		I Fore	sirthplace (State or eign country) ew York
*		Usual Residence of Decedent			, Town or Loc	ation							10d. Inside City Limits
ow any		10a. State 10b. County  Maryland Prince	ce Georg		Bow								1 X Yes 2 No
aryland 8a-f sh	Director	10e. Street and Number		,	DO N	10f. Zip C	ode				10g. Citizen	of What Co	ountry?
the M. ia or 2:	Direct Control	6413 Glydon Co	ourt				2072					S.A.	
th with ems 23 t be ng	Funeral	11. Mantal Status 1 X Never Married 2 N		Decedent Ever in U ed Forces?	J.S. 13. V	Vas Decedent Yes, specify	t of Hispa Cuban, I	anic Ongin Mexican, F	? (Spec Puerto R	cify Yes or N ican, etc.)	0~ 14.	. Race - Am White, etc.	erican Indian, Black,
ter dea	Fur			es 2XX No	1	Yes 2	No	specify:			Sp	ecify: B	lack
ours af atural	d by	15. Decedent's Education (Sp	or Dates:			ent's Usual O most of worki					16b. Kind	of Busines	s/Industry
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland  mportant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12 12th grade		ge (1-4 or 5+)		ployed	l					Unemp	loyed
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212 ould be Menta marko	o Be	19a. Informant's Name/Relation			19b. <b>M</b> ai	ing Address	(Street	and Numb	er or Ru	ural Route No	umber, City	or Town, St	ate, Zip Code)
MD d 2 sho lth and n 27 is		Vincent A. Lise	er (Fath	er)	1200	0 Manc	hest	ter W		Bowie,	Mary	land	20720 or Town, State
ore, es lan of Hea If iter		20a. Method of Disposition  1 Burlal 2 X Crematic	on 3 Remo	val from State Me	Place of Disp crematory of Tropol	other place)	e or cem C <b>rem</b> a	atory.	~/^^	/aco	200. 200		
t. Pagrament rant:		4 Donation 5 Other 21. Signature of Funeral Service			Inc	Name and	Address	of Facility	Mars	/2009 shall	s Fun		ria, Virgini Home,Inc.
Bal permi Depar Impo injur		1. P. Mar	MON	10	4	217 9t	h St	treet	, N.	.W. Wa	shing	ton, I	-
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, P.O. Box 687/ res that the death certifice signed by the attending pl	sician/	23b. Was decedent pregnant in past 12 months?	the 1 4	Live birth Pregnant at time of	2	Fetal death Other (Spec	3 [	Ectopic	pregnar	ncy	٨	Aonth .	Day Year
by the	Phy	Part II. Other significant con-	9	Unknown uting to death but no	ot resulting in t	he underlying	cause g	iven in Pa	rt 1.				e to the cause of death?
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OD C lending sath. or: Afi	tion	1 Natural 5 Pe	ariumy C-	. Date of Injury (Month, Dey,Yeer) UND: pp 13, 2009	FOUND 0300 hrs		1	Yes 2 🗸	No	Subject s			
Division tal or Attendii rs after death. at Director: A	Certification:	3 Suicide 6 C	ould not be	e. Place of Injury - A	t home, farm,	street, factory	, office b	ouilding, et		or Tow	n. State)		or Rural Route Number, C nington, DC
Division of Vital Records, P.O. Is to the Hospital or Attending Physician: The law requires that the within 24 hours after death. The the Funeral Director. After this centificate has been signed by the completely filled in by the funeral director, page 2 should be deached completely filled in by the funeral director, page 2 should be deached.	Medical C	202 Certifier	xaminer: On the	the best of my knowledge basis of examination	ledge, death on and/or inves	occurred at the	e time, da y opinion	ate and pla	ace, and courred a	I due to the cat the time, d	ause(s) and ate and place	d manner as ce, and due	stated. to the cause(s)
of will	Me	29b. Signature and title of cer		anner stated.		29	c. Licens	se number M.E.				Date signed tember 1	(Month, Day, Year) 3, 2009
7		30. Name and address of pers Ling Li, MD Assis	on who complete stant Medical		tem 23a) 11 Penn S	treet, Balti	imore,	MD 212	201				
	State	21 2 1 2 1 2 1 2 1 2 1	nha A	32. Registrar's Sign									
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		1 - For State Registrar	State of	Maryland		artmen rtificat			ınd M		giene Reg. No.	005	31302
Physici	an	1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	Day	Yeer	3. Time of Death
/Medic		Gene Allen Myers								Septemb			9 2:30 P. M
Examir	ier,	4a. Facility Name (If not institution, give		rer)		,		Location of	f Death			ounty of Dea	
		253 Pennsylvania  5. Social Security Number 6.5		Age (In yrs. la	st hirthday)	If Under	ncoc 1 Year	K. If Under 2	24 Hrs.	8. Date of Birt		ashing	thplace (State or Foreign
Funeral Director			1 M 2 □ F		66 Yrs.	Months	Days	Hours	Min.	(Month, Da) Feb. 16,	v. Year)	MI	ountry)
land ow		10a. State 10b. County		10c. City	Town or Lo	cation							10d. Inside City Limits
the Marylan 28a-f show	ţŏ	MD Washing	con	Hane	cock								1X Yes 2 No
n the	irec	10e. Street and Number		1		10f. Zip	Code				10g. Citize	n of What Co	ountry?
th wit	a D	253 Pennsylvania	a Avenue			217	750				USA		
I and 2 should be filed within 72 hours after death with the Maryland is 1 and 2 should be filed within 72 hours after 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, tra Madical Examinations to Little delined at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date	es? ⊠No		Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:				cify Yes or No Rican, etc.)		Black, Whi	erican Indian, te, etc. nite
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2 sho and ts m		19a. Informant's Name/Relationship				-				l Route Numbe	-		Zip Code)
1 and Health Health Sem 27 other tr	ļ.,	J.Russell Robinso	n,III/Att		152 W ace of Dispo			on St		erstown			Town State
ges 1 t of H if ite or ot	1	20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 [	Removal from St	ate Ce	metery, crei	natory or o	ther plac					·	Town, State
tmen tant:		'4 ☐Donation 5 ☐ Other (Speci	**	Par	khead					/2009	Big P	ool, 1	1D
permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr QDCE.		21. Signature of Funeral Service Lice	Save 1	19020				ss of Facility ral H	1	41 West P.A.Har		170.0	et 750 <b>-</b> 0368
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Attending For death.  ector: After by the funer.	Certification:	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	(Month,	Day Year)	Injury	М	- I	k? Yes 2⊡	No				2-18-1-1
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To t To t	Σ	29b. Signature and title of certifier	Moses 1	<i>б</i> ).		290	c. Licens	e number	5		29d. Date	signed (Mor	oth, Day, Year)
31		30. Name and address of person who	completed cause	. () -	23a) (Type,	Print)	54	. H	1000	ratal	en i	mD.	21740
Sta Regist		31. Date filed (Month, Say, Year)	2000 32. Re	Strat Signat	ure	1	0 0	21	1	, , , , ,			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER Day 23 2009 **Physician** 9:30 Рм PAUL EDWARD MAIN /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 € M 2 □ F 220-18-2214 Director 83 1926 Maryland June 14, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show event, the Medical Examiner must be notified at Maryland Frederick Director Frederick 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 218 Wyngate Drive 21701 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Types 2 No Iryes, Give 944-1946 Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if flem 27 Is marked other than "natural", or any injury or other traumatic event, the Medical Evanthone. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Audio Specialist/Supervisor US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William H. Main Flora E. Carpenter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mildred Grove-Main, wife 218 Wyngate Drive, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 \( \overline{\overline{A}}\) Burial 2 \( \overline{\overline{C}}\) Cremation 3 \( \overline{\overline{A}}\) Removal from State 4 \( \overline{\overline{A}}\) Donation 5 \( \overline{\overline{A}}\) Other (Specify) Mount Olivet Cemetery Sept. 29, 2009 Frederick, MD 21. Signature of Funeral Service Liver see Keeney and Bastord PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest se on each line. Immediate Cause (Final **Physician** W1530 Eneurym < TIA disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Tens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2.ET NO 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Hospital in 24 hours after deam.
ihe Funeral Director: After this maletely filled in by the funeral di Certification: To 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Natural Natural 1 ☐Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09689

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

30

2

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)
Austin Pearre, M.D., 300 West Ninth Street, Frederick, MD 21701

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			Please		aryland / De	oartmen	e Ink. Ensure A	Mental Hyg	jiene	0100
			Registrar  1. Decedent's Name (First, Middle, L	.ast)		eruncau	e of Death	2. Date of Dea	th 6, Day 2009 Year	3. Time of Death
	Physic /Medi			erman Benja	min MINDE	L		Sept. 1	12:45 P M	
-35	Exami		4a. Facility Name (If not institution, g 13308 Rockview			4b. City,	Town, or Location of Deat ver Spring		4c. County of Death	
	Funeral Director		578-42-6335	Sex 7. Age	e (In yrs. last birthda 80 Yrs.	y) If Under Months		8. Date of Birth (Month Da) April I	8, 1929 Was	nplace (State or Foreig untry) Shington, [
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limit
	a-f sh	ctor	Maryland Montgor	nery	Si	lver S	pring			1 □Yes 21/□N
	or 28	Dire	10e. Street and Number			10f. Zip			10g. Citizen of What Co	
	ath w	ral	13308 Rockview				20906		United Stat	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Neutral Event in a trust the neithed at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2011 If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Deced If Yes, spe 1 ☐ Yes	dent of Hispanic Origin? (scify Cuban, Mexican, Puer Mondan)	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
5-0	72 ho 'natur	etec	15. Decedent's (Specify only highest of	Education grade completed)	16a. De	cedent's Usu ve kind of wo	al Occupation ork done during most of wo se retired)	rking	16b. Kind of Business/I	ndustry
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College 1-4or 5	T)	. <i>во мот и</i> . altor	se retired)		Residentia	Realty
and 2	12 should be filed within the and Mental Hygiene. 7 is marked other than "traumatic event, the Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Menta	Be	17. Father's Name (First, Middle, La	Abraham M		<u></u>			Maiden Surname)	
Maryl	id 2 should lith and Me 27 is mark	2	19a. Informant's Name/Relationship Shirley J. Mind	(Type. Print) el, wife	1330	iling Address 8 Rock	s (Street and Number or R Kview Court,	ural Route Numbe Silver S	r, City or Town, State, 2	^{Tip Code)} 20906
Baltimore, Maryland 21215-0036	Pages 1 and nent of Health nt: If item 27 iry or other to		20a. Method of Disposition  1 ABurial 2 Cremation 3 4 Donation 5 Other (Spe		20b. Place of Dis		me of other place)  Gardens (	Date	20c. Location - City or Olney, MI	
Balti	permit. Pages 1 Department of t Important: If ite any Injury or ot once.		21. Sign ture of rune (Service Li)	ensee M	01008	forcht	nsky Mebrew irroll St., N	Funeral	Home	20012
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each lir	the death. Do not ne.		A		L.	Approximate Interval Between Onset and Death
	Physician /Medical Examiner	Ì	Immediate Cause (Final disease or condition resulting in death)		a confequence of):	ve	Acute Le	ukem	دم	14 ho
		xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	e consequence of):					
68760, [™]	cate be executed physician and the burial-transit	ш	that initiated events resulting in death) Last	cDue to (or as	a consequence of):					
O. Box 68	that the death certificate be ed by the attending physicia detached for use as the bur	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic p			23d. Date of del Month	ivery Day Year
σ.	es ga	by	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying o	cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Records	law has b	Completed						24a. Was autop	sy prior to o med? death?	topsy findings availab completion of cause o
Vital	ian: The	O O	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only of		2 No
of V	nysic iis ce direc	To B	examiner? 1 □ Yes 2 ☑ No	Hospital:	ent 2 ER/Outpa			Home 5 ₹ Resid	lence 6 Other (Spe	cify)
	ling After uner	ertification:	27. Manner of Death  1 Natural 5 Pending investigat		ry 28b. Time y, Year) Injur	of 2	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe h	ow injury occurred	
Division	or Attendate death after death Director:	ertific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Inju	ury - At home, farm, c. (Specify)	street, factor	y, office	28f. Location (5 City or Tox	Street and Number or Ru n, State)	ıral Route Number,

To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page Be Medical Certification: To

	1 ☐ Yes 2 ☑ N	0
ı	27. Manner of Death	
ı	1 🔁 Natural	5 Pending
-1	2 Accident	investiga

BALTIMORG

29a. Certifier (Check only one)

18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mb

29c. License number D0047398 29d. Date signed (Month, Day, Year) 2009

MD

21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOUGLAS 31. Date filed (Month, Day, Year)

SEP 17 2009



State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 3:27 aM Middleton September 12 2009 Carmella Anne /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗷 F Yrs. Director 578-24-0968 District of Columbia June 11, 1924 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 1 X Yes 2 No Director 28a-f Maryland Prince George's Laure1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ament of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or: ury or other traumatic event, Ite Model Examing In sist ber ury or other traumatic event, Ite Model Examing In sist ber 20707 7118 Piney Woods Place U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: Specify Completed by 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mortgage Banker Banking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Joseph Sciacca Rose Clements 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7118 Piney Woods Place, Laurel, Maryland 20707 George R. Middleton - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of I Important: If ite any Injury or ot 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 09/18/2009 Brentwood, Maryland 21. Signature of Funeral Service (Ge)see 10 #1070 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cardiorespiratory Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Severe Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Pneumonia ending physician and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical cate has been signed by the attending page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Ye ar 5 Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. Completed by Chronic Atrial Fibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? Chronic Obstructive Pulmonary Disease 24a. Was an autopsy performed' 1 ☐Yes 2 No 2 No or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 X No Certification: To 1 ■ Inpatient 2 ■ ER/Outpatient 3 ■ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 ☐ Pending investigation 1 X Natural ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide Hospital within 24 hours a 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical pletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

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31. Date filed (Month, Day, Year) 32. Registrar's Signature 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maria Jeraldine Tayag,

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29c. License number

M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910

D63579

29d. Date signed (Month, Dav. Year)

September 12, 2009

Ammend 10e / 19b 9/18/09 CCHD/KW

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

3. Time of Death

**Physician** /Medical Examiner 1. Decedent's Name (First, Middle, Last) Suzanne Marie McClanahan 4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

1 🗆 M

4b. City, Town, or Location of Death

Annapolis

Month 09/10/2009 02:15 a^M 4c. County of Death

Anne Arundel

Funeral

Director show r than "natural", or items 23a or 28a-f shov Director death with the Funeral permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Examina. once. Š Completed

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Baltimore, Maryland 21215-0036

10c. City, Town or Location 10b. County Barstow Calvert

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/27/1955 Days

9. Birthplace (State or Foreign Washington, DC

10d. Inside City Limits

1 ☐ Yes 2 No

214-60-3024 Usual Residence of Decedent 10a. State

5. Social Security Number

10e. Street and Number Oe. Street and Number Hallowing 2670 Holland Point Road

10f. Zip Code P.O. Box 137

7. Age (In yrs. last birthday

54

20610

10g. Citizen of What Country?

16b. Kind of Business/Industry

U.S.A.

11. Marital Status

MD

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2X Married 3 Widowed 4 Divorced

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐Yes 2X No Specify

16a. Decedent's Usual Occupation

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

1 ∐Yes 2 No If Yes, Give Year or Dates:

(Give kind of work done during most of working life. DO NOT use retired) Civil Process Specialist Calvert County Sheriff Department

17. Father's Name (First, Middle, Last)

Elementary/Secondary (0-12)

18. Mother's Name (First, Middle, Maiden Surname) Juanita Marie Clark

Jean Dayton Domingue

19a. Informant's Name/Relationship (Type. Print) John McClanahan/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 2670 Holland Point Road, Barstow, MD 20610

uncer with verforation

Hallowing 20c. Location - City or Town, State Date

20a. Method of Disposition

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory

09/11/2009 Clinton, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A.

21. Signature of Funeral Service Licenses

Lisa M. Mounts

8125 Southern Md Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Year

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**Physician** /Medical **Examiner** 

burial-tra

the as attending p

physician

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page 2 should

certificate

ors after death.

eral Director: After this certificalled in by the funeral director,

within 24 hou To the Fune completely file

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Examine

Physician/Medical

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Completed

Be

Medical Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

500000 Due to (or as a consequence of):

(MUSUCH 12) Due to (or as a consequence of)

Due to (or as a consequence of)

23d. Date of delivery

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 - Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown

Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes

25. Was case referred to medical examiner?

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☒ No 1 ☐Yes 2 ☐ No 26. Place of Death Check only one

2 No 1 ☐ Yes 27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be

determined

28b. Time of Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number D0044979 29d. Qate signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2002 Medical Parkway, Suite 360, Annapolis, MD 24101 Janet L. Wasson

and manner stated.

My July mo

State Registrar 31. Date filed (Month, Day, Year) 32. Re SEP 15 2009

32. Registrar Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Par 14, 2009 12:05 Joseph Brady McLellan 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Mechanicsville St. Marys 39780 Hiawatha Circle 8. Date of Birth June 15, 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Sex 1XDM 2□ F Year 943 Days Hours Min. Months 66 578-58-5039 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 No Mechanicsville MD St. Marys 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20659 USA 39780 Hiawatha Circle 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 🏋 No 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dept. of Justice College (1-40r5+) Elementary/Secondary (0-12) Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard McLellan Kathryn Fitts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne McLellan 39780 Hiawatha Circle Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary Queen Of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 Removal from State September Helen, Maryland 5 Other (Spegify) Peace Cemetery 18,2009 1. Peace Cemetery 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Holmes 8125 Southern Maryland Blvd. Owings, MD20736 18,2009 4 Donation M01464 n F. Holmes

Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funera

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Completed

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**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventinar must be notified at once.

Baltimore, Maryland 21215-0036

sician and burial-trans attending physician for use as the buria certificate has been signed by the atte irector, page 2 should be detached for i

Hospital or Attending Physlcian: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examine Be Completed by Physician/Medical within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To

	7 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 -		<i>y</i> —	0,
23a Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	ot enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of c. Due to (or as a consequence of d.			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?  No 3 Probably 4 Unknow
			24a. Was an autopsy performed? 1 □ Yes 2 2 10 No	24b. Were autopsy findings availab prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of D	eath (Check only one)	
examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pending investigation	, , , , , , , , , , , , , , , , , , , ,	me of ury 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how injur	y occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street an City or Town, State	nd Number or Rural Route Number,
29a. Certifier (Check only one) Certifying Physical Example 2 Medical Example 2	ysician: To the best of my knowledge, ilner: On the basis of examination and and manner stated.	death occurred at the time, date and pla //or investigation, in my opinion, death oc	ce, and due to the cause(s curred at the time, date and	and manner as stated.  d place, and due to the cause(s)

DRW)

State Registrar

29b. Signature and title of certifier

29c. License number H0055751 29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

M.D. 40900 Merchants Lane Suite 205 Leonardtown, MD 20650 Jennifer Schmidt,

32. Registraris Signature 31. Date filed (Month, Day, Year) 2009

09-07212 Beasley McIvey

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	-	30. Name and ad	dress of perso	on who con	apleted ca	ause of dea	ath (Item 23	Ba)										
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ı	21. Signature of Funeral Service	e Licensee			22.	Name and	Address	of Facility	Mars	hall'	s Fun	eral	Home
ini In Derr	i	a o marsh	all M	097	7	4:	217 9t	h S	t NW	Washi	ngton	DC 2	0011	Approximate Interval
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Division of Vital Records, P. and or Attending Physician: The law requires the safter death.  The Director: After this certificate has been signe led in by the funeral director, page 2 should be death.	2	1 ✓ Yes 2 No 27. Manner of Death	28a. Da	te of Injury	28b.			28c. 1nj	ury at Wor	k? 28	d. Describe	how injury	occurred	
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physocompletely filled in by the funeral director, page 2 should be detached for use as the b	g	(Check only 1 Certifying one) 2 Medical	Physician: To the Examiner: On the bas	best of my k	nowledge, de nation and/or	investi	igation, in m	y opinio	on, death o	occurred at t	he time, dat	and place	e, and due	to the cause(s)
Division  To the Hospital or Attend within 24 hours after death wither 12 hours after death completely filled in by the	Medical		and manne	er stated.					nse numbe			29d. Da	ate signed	(Month, Day, Year)
L,	Σ	29b. Signature and title of ce	.// -/	^					.M.E.			Septe	ember 1	6, 2009
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5	1	30. Name and address of per		ause of dea	th (Item 23a)	<b>D</b> r	111 Pon	n Stro	et Ralti	more, MI	21201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 1115 P^M 09 2009 15 Sheila Marie McGill /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🕱 F 43 579-94-8032 03/09/1966 DC Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1X Yes 2 □ No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20902 USA 10307 Brunswick Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Process Control Associate IC Marc 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norman McGill Mildred Jones ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred N. Rollins/mother 10307 Brunswick Ave. Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/22/2009 Creek Cemetery |Washington DC 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 23a. P. Ir.M. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4217 9th St NW Washington DC 20011 Immediate Cause (Final disease or condition resulting in death) Staphylococcus Lugdunensis Sepsis Due to (or as a consequence of): Metastatic Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of, Hepatorenal Syndrome Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐Yes 2 🛣 No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 24a. Was an 1 □Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)

24 hours a

State Registrar

DHMH 17 Rev 1/2001

Director

is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Its Medical Examinations in the profiled at

21215-0036

Baltimore, Maryland

Pages 1 and 2

P

Department of Important: If it any injury or conce.

**Physician** 

/Medical

Examiner

attending physician and for use as the burial-transi

cate has been signed by the atter page 2 should be detached for

this

the Director:

death

Box 68760.

P.O.

Division of Vital Records,

or Attending Physician: The law requires that the death certificate be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pothy Nagabhiru, MD

31. Date filed (Month, Day, Year,

D63639

1500 Forest Glen Rd. Silver Spring, MD 20910

9/16/2009

			se Type or Prin State of Ma	it in Black I aryland / De				-		_	9.		
	-	for State Registrar			ertificate				Reg. No		0 0107		
		Decedent's Name (First, Middle)	e, Last)					2. Date of D	eath	- 111	3. Time of Death		
Physicia /Medic		William Herber						Septem1	ber :	12, 200	09 10:40 pM		
Examin		4a. Facility Name (If not institution Laurel Regiona			4b. City,		Location of Dea	th	4c. County of Death Prince George				
Funeral				e (In yrs. last birthda			If Under 24 Hr	s. 8. Date of B			Birthplace (State or Foreign		
Director		5. Social Security Number  189-22-8480  18 M 2 F  7. Age (In yrs. last birthday) 81 Yrs.  18 Months Days Hours Min.  Wonths Days Hours Min.  19 June 23, 1928									Country) Pennsylvania		
filed within 72 hours after death with the Maryland Hygiene. Vither than "natural", or Items 23a or 28a-f show ent, the Modical Examiner must be notified at	ctor	10a. State 10b. County	ntgomery	10c. City, Town or	Location .ver Sp	ring					10d. Inside City Limits 1 ☐ Yes 2 No		
with the	Director	10e. Street and Number 3128 Gracefie	ld Pond T-1	1	10f. Zip	Code 209	<b>Ω</b> 4		10g. C	t Country?			
sath	era				2 Mac Deced			Specify Vec or N	L		American Indian,		
s after de , or item	by Funeral	11. Marital Status  1 Never Married	If Vac Give	Korean	If Yes, spec 1 ☐ Yes 2		Specify:	Specify Yes or N rto Rican, etc.)	40-	Black, W	Vhite, etc.		
ural"	9	3 Widowed 4 Divorced	Year or Dates:C	0111111							White		
thin 72 h ie. ian "natu Medica	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t's Education at grade completed)  College (1-4or 5	(Gi	cedent's Usua ive kind of wor e. DO NOT us	k done di	uring most of w	orking		Kind of Busine ationa	ess/Industry 1 Electrical		
d wii	5		4		Cost	Engi	neer		C	ontrac	tors Assoc.		
al Hy loth	Be (	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)											
uld b Ment Irkec	2	Herbert Charles Paules Helen Irene Fogel											
old 2 sho alth and I 27 Is ma r trauma		19a. Informant's Name/Relationsh Regina Marie P									te, Zip Code) ring, MD 20904		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Modical Examiner must be notified at once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation		20b. Place of Discemetery, c	rematory or of	her place	eterv	Sept. 1	1	·	or Town, State		
rmit. Pa spartmel portant iy injury ICE.		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service I		0430 01	22. Name and	Address	of Facility in	2009 s Funer	al H	ome In	ring,Maryland		
89789		Muche	Hole		500 Un	iver	sity Bl	vd. W.,	Sil	ver Sp	ring, MD 2090		
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediace (Final disease or condition resulting in death)  Gastrointestinal Bleeding  Due to (or as a consequence of):											
		Sequentially list conditions,		b. Non-Specific Colitis  Due to (or as a consequence of):									
be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		consequence of):							years		
be exection and cian and purial-tran	Exa	resulting in death) Last	G,	a consequence of):									
g cg. Be			Myelodys	Myelodysplasia									
To the Hospital or Attending Physiclan: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the beautiesty.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2  Fetal death	3 ☐ Ectopic pr 5 ☐ Other (sp					23d. Date of Month	f delivery Day Year		
ires that signed b	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute									te to the cause of death?		
requ been should	eted	1   Yes 2   No 3   Prob											
The law ate has page 2 s	Completed							24a. Wa aut per 1 □Yes	opsy formed?	24b. Were prior deat	e autopsy findings available r to completion of cause of th? Yes 2 □ No		
Jan: ertific stor,	Be	25. Was case referred to medical examiner?					26. Place of De	eath (Check only					
ysic lis ce direc		examiner? 1 ☐ Yes 2 <b>K</b> No	Hospital:	nt 2 ER/Outpat	ient 3 DO	A Other	r: 4 ☐ Nursing	Home 5 ☐ Re	sidence	6 ☐ Other (	Specify)		
ding Pt th. : After the funeral	tion:	27. Manner of Death  1   Natural  2  Accident  Accident	28a. Date of Injur (Month, Day	ry 28b. Time (, Year) Injur	e of 28	3c. Injury Work? 1 □ Y	at es 2 □ No	28d. Describe	e how inju	ury occurred			
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To the Hospital or Attending Physiclan: The law requires that the di within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical C		g Physician: To the best of Examiner: On the basis of and manner sta	examination and/or									
o the	Mec	29b. Signature and title of certifier	-	itou.	290	License	number		29d. Date signed (Month, Day, Yea				
5+1			4			2403					12, 2009		
		30. Name and address of person v Eugenio Macha		eath (Item 23a) (Typ 8110 Grace		Road	, Silve	er Sprin	q,MD	20904			

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) SEP 16 2009

A. Registrar's Signature

			1 - State of Maryland / Dep Registrar Ce	artment of Health and N <i>rtificate of Death</i>	Mental Hygiene				
			Hegistrar     Decedent's Name (First, Middle, Last)	Timoate of Beatin	2. Date of Death	3. Time of Death			
	Physici /Medic		Cheryl R. Powell		September 13 20	09 3:14 A. ^M			
a sold	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death					
			Fort Washington Hospital	Fort Washington		George's			
b	Funeral Director		5. Social Security Number  6. Sex 1 M 2 M F 7. Age (In yrs. last birthday, Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	(Month, Day, Year)	Birthplace (State or Foreign Country) aryland			
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Li	ocation		10d. Inside City Limits			
	Maryl f sho	jo				X Yes 2 No			
	r 28a	Director	Md Charles Bryans  10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	at Country?			
	th wit	a D	720 Strawberry Court	20616	USA				
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, it we had a Framing rougher and event, it we had be reamined.	by Funeral	11. Marital Status  1 X Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 XNo Specify:		American Indian, White, etc. Black			
5-0	72 ho	etec	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	16b. Kind of Busin	ness/Industry			
121	within jene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)					
d 2	a filed val Hygie other i	ပိ	12th Disa		None e (First, Middle, Maiden Surname)				
an	nould be to Mental marked o matic eve	To Be	Bobby J. Powell	Martha	Sharps				
ary	50 E 10 5		19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and Number or Rur					
Σ,	고 <del>보</del> 다 무		Takisha Brown/Daughter 1281	Brentwood Rd #3 1	NE Washington,DC	20018			
ore	ges 1 t of H If Iten or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State	matory or other place)	Date 20c. Location - Ci				
tim	t. Pag tment tant:		4□Donation 5□Other (Specify) Riverdal		1/2009 Riverdale	,Maryland			
Baj	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other		D-5/ /	2. Name and Address of Facility J 474 Landover Road	. B. Jenkins Fun Landover, Maryla				
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between			
***	Physician		Immediate Cause (Final disease or condition a. CARDIAC ARRHYT	HMIA		Onset and Death			
and the	/Medical Examiner		resulting in death)  Due to (or as a consequence of):  DILATED CARDIO	WV OD ATUV					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	TIOI AIIII					
	uted f insit	Examiner	Cause (Disease or Injury III FERTEIN STON						
Ć,	an and ial-tra	Еха	that initiated events resulting in death) Last C						
68760,	ficate be executed physician and s the burial-transit	dical	d. RENAL FAILURE						
89	ertifica ing ph as th	w 1	IF FEMALE:						
Box	ires that the death certif signed by the attending i be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1   Ves 2 FBNo 4   Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of Month	· ·			
P.O.	at the by the tache	hys	9 ☐ Unknown						
Vital Records, I	law requires that the death certif as been signed by the attending 2 should be detached for use as	þ	Part II. Other significant conditions contributing to death but not resulting in the uPULMONARY HYPERTENSION	nderlying cause given in Part I.	23e. Did tobacco use contribution 1 Tyes 2 No 3	ute to the cause of death?			
000	law requir as been s 2 should	Completed	END STAGE RENAL DISEASE		24a. Was an 24b. We	re autopsy findings available			
m	The ate h	mo			nerformed? des	or to completion of cause of ath? ∃Yes 2 ∰No			
ita	ilcian: Th certificate ector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Deat	th (Check only one)	169 2 23190			
of <	Physician: r this certificaral director, p		1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatie	nt 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 Other	(Specify)			
ion	ding h. After fune								
Division	i ji fe								
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in	ledical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea 2  Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	, and due to the cause(s) and mannered at the time, date and place, and	ner as stated. d due to the cause(s)			
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	. /		Town wester Some	D08370	September	r 16, 2009			
Z	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Paul Pritchett Sr. M.D. 118 Lagran	nge Avenue LaPlata	,Maryland 20646	)			
	Sta Registra		SEP 1 8 2009 SEP 1 8 2009 Server S. Agare	i					

DHMH 17 Rev 1/2001

# Baltimore, Maryland 21215-0036

	EX
Division of Vital Records, P.O. Box 68760,	Hospital or Attending Physician: The law requires that the death certificate be executed
Division of Vital	Hospital or Attending Physician:
	Ž

		Please	Type or Pri				Ensure Allealth and M	-	_	ible.		
	1 - For State Registrar		State of M	ai yiai k		tificate of			Reg. No.		31373	
	1. Decedent's Nam	ne (First, Middle, L	ast)					2. Date of Dea Month	ith Day	Year	3. Time of Death	
Physician /Medical	SUE		SPRUILL		PAR	KS		Sep 10 2009 1:56 p M				
Examiner			ive street and number,				Location of Death			ty of Death		
	5. Social Security I		's Hospita		ast birthday)	Chever:	Ly If Under 24 Hrs.	8. Date of Birt	h		orge's place (State or Foreign	
Funeral Director	237-78-9		1 □ M 2 □ F	63	Yrs.	Months Days	Hours Min.	(Month, Da AUG 30	y, Year)	Cou	TH CAROLINA	
	Usual Residence of	of Decedent										
show	10a. State	10b. County			, Town or Lo						10d. Inside City Limits 1 X Yes 2 □ No	
or 28a-f sl	MD 10e. Street and Nu	1	GEORGE'S	CH	IEVERLY	10f. Zip Code			10g. Citizen of	What Cou	ntry?	
3a or	6339 LAN	NDOVER RO	AD # 302		20785 USA							
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Wher then "natural", or items 23a or 28a-f show ent, the Maryland Examinant be notified at the Maryland Examinant Director Schools of Maryland Director		ried 2 ☐ Married	12. Was Decedent Armed Forces? 1	•		Vas Decedent of H fYes, specify Cuba □Yes 2XNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ace - Ameri ack, White,		
n 72 hour "natural" edical Ex	o i jaj maonea	15. Decedent's B			16a. Deced	lent's Usual Occup	ation		16b. Kind of I	Business/Ir	ndustry	
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be file ad oth even	17. Father's Name	(First, Middle, Las					18. Mother's Name	•		me)		
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id 2 sh Ifth an 27 is r traur						-						
f Health frem 27 other tr	20a. Method of Dis	C. PARKS/ sposition	DAUGHTER	20b. PI	lace of Dispo	sition (Name of		1 202 L Date	ANDUVE. 20c. Location		YLAND 20785 own, State	
Pages nent of int: If It			Removal from State			natory or other plac NS CEMET		2009	CHELTE	NHAM,	MARYLAND	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ire IV once.	21. Signature of Fundral Service Acensee 22. Name and Address of Facility J.B. Jenkins Funeral Home											
20 E # 9	7	u			- 1		ver Road,			20785		
Physician	shock, or he Immediate Cause disease or conditi	art failure. List onl (Final ion	mplications that cause y one cause on eaut if e.	ne.	tic	ar the mide of ayir	g, such as cardiac	or respiratory ai	rest,		Approximate Interval Between Onset and Death	
/Medical Examiner	resulting in death)	ſ	Due to (or as	nsequ	ience of):	2011	note					
executed in and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last resulting in death) Last.											
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w requires that the debeen signed by the should be detached letted by Physic	Tare III. Other digit	ificant conditions	contributing to death b	out not resu	ilting in the ur	nderlying cause giv	en in Part I.		obacco use co ⁄es 2 □ No		the cause of death? bbably 4 💢 Unknown	
: The law requir cate has been s page 2 should								24a. Was	an 24b	. Were aut	opsy findings available ompletion of cause of	
cate ha								autop perfo 1 □ Yes	rmed? 2√ZNo	death? 1 ☐ Yes	2 ☑ No	
clan: ertific ector, Be (	25. Was case refe examiner?	rred to medical	/			I	26. Place of Deat					
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ding h. After funer	27. Manner of Dea	5 ☐ Pending investigation	28a. Dáte of Inji (Month, Da		28b. Time of Injury	28c. Injur Worl M 1 □	yat k? Yes 2 □No	28d. Describe I	now injury occi	irrea		
i or Attending Physician: after death. Director: After this certifica d in by the funeral director, g ertification: To Be C	2 ☐ xccident 3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 28e. Place of In	ury - At ho tc. (Specify		eet, factory, office	100 2 2.110	28f. Location (8 City or Tov		nber or Ru	ral Route Number,	
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pag	29a. Certifier (Check only one)		Physician: To the best aminer: On the basis and manner si	of examinat								
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21	30. Name and add	ress of person who	completed cause of a	death (Item	23a) (Type,	Print)	Chivin	he m	1/1 n 2/	78	5	
State	31. Date filed (Mon		32. Regist	rar's Signat	ure		AICTE	7	0 20	, ,		
Registrar	SEP 1	8 2009	Denewa & B	40	uti							

DHMH 17 Rev 1/2001

			State of Maryland / Dep	eartment of Health and ertificate of Death			913
	_		Registrar  1. Decedent's Name (First, Middle, Last)	Tillicate of Death	2. Date of Dea	eg. No: U u v	3. Time of Death
ı	Physici /Medio		Joseph Reynard		SEP. 11	Day Year 2009	5:12 A. M
and the last	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Dea	
and d			Holy Cross Hospital	Silver Spring		Montgome	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 81 Yrs.	) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		Year) C	thplace (State or Foreign ountry) aica
	pus w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	Maryla • sho • ied at	ō	Maryland Montgomery Takoma Pa				Y Yes 2 No
	r 28a	Directo	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	ountry?
	th with	ral D	666 Houston Avenue, Apt. 315	20912		United Sta	tes
36	be filed within 72 hours after death with the Maryland that Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Madical Evaminer must be notified at	by Funeral	1 ☐ Never Married 2 【 Married ☐ Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 Tyes 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify: B1	e, etc.
9	2 hour		15. Decedent's Education 16a. Dec	edent's Usual Occupation		16b. Kind of Business	
1215-0036	vithin 72 ne. <b>han "n</b> a Madi	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of wor DO NOT use retired)	rking		
2	filed withi Hygiene. other than ent, Italia	ပ္ပိ	11 Farme		ne (First, Middle, I	Agricultur	e
Maryland 21	~ = 0 9	To Be	Abraham Reynard	Grace E	, , ,	naideir Surriame _j	
ary	S P E E	F		ing Address (Street and Number or Ru		, City or Town, State,	Zip Code)
	is 1 and 2 is 1 and 2 is 1 Health a item 27 is other train		Sheryl Reynard, Daughter Albe	rt Town, Stettin	District	, Trelawny	, Jamaica
altımore,	Pages 1 nent of H ant: If iter ary or oth			matory or other place) ¦ (CT	Date 4.	20c. Location - City or	Town, State
<u>=</u>	it. Pac rtmen rtant: njury		4□Donation 5□Other (Specify) Stellin	Seventh Day 2009		Trelawny,	
g	permit. Page Department of Important: If any injury or once.			2. Name and Address of Facility Thibadeau Mortuary 33 Gist Ave., LL,			20910
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  END-STAGE RENAL I		c or respiratory arr	est,	Approximate Interval Between Onset and Death YEARS
	/Medical Examiner		Due to (or as a consequence of):  PULMONARY EDEMA				WEEKS
-	B +	ner	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying				WEEKS
2	ecute and transi	Examiner	that initiated events c. CONGESTIVE HEART	FAILURE			WEEKS
8/60,	ficate be executed physician and s the burial-transit		Due to (or as a consequence of):				
20	tificate g phy as the	edical	d				
O. BOX	e death certific the attending p	Physician/M		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	livery Day Year
	that the ed by detacl		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tol	pacco use contribute to	o the cause of death?
ecoras	ding Physician: The law requires that the de n. h. After this certificate has been signed by the funeral director, page 2 should be detached	ted by	ATRIAL FIBRILLATION, DEMENTIA, TYPE 2		11		robably 4 Unknown
ဋ	has be	Completed	MELLITUS, CEREBRAL VASCULAR ACCIDENT		24a. Was a	y prior to	utopsy findings available completion of cause of
<u> </u>	n: The ficate r, page				perförr 1 □ Yes	ned? death? 2⊠No 1 □ Yes	2 <b>20</b> 0
\ \ \	siciar certifi irector	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: 1 Inpatient 2 ☐ ER/Outpatient	Other	th (Check only on	<u> </u>	
5	g Phy ter this neral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at		ence 6 Other (Spe ow injury occurred	ecify)
202	endin eath. or: Aff he fur	atio	1 SAatural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	Work?  M 1 □Yes 2 □No			
Ž	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal on the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	e, and due to the curred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the Complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex	ž	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Moni	th, Day, Year)
	1		Barbara Supanich, RSM No	D 0065485		09-11-	7009
			30. Name and address of person who completed cause of death (Item 23a) (Type BARBARA ANN SUPANICH, M.D., 1500 FORE	,	VER SPRTI	NG. MD 209	10
	Stat	e	31. Date filed (Month, Day, Year) 37. Registrar's Signature		DINI	, 207.	
	Registra	ir	SEP 16 2009 Person A. Ala	Carried .			

		1	State of Maryland / Department of He  State			jiene _{leg. No.}	3 1375
			1. Decedent's Name (First, Middle, Last)		2. Date of Dear		3. Time of Death
П	Physicia		Bernard R. Rappaport		Month	Day Year Der 11, 200	09 2:45 P M
-Erak	/Medic		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Lo	ocation of Death	<u> Бересии</u>	4c. County of Dea	
	Examin	er	Montgomery General Hospital Olney			Montgomer	r 17
			5 Social Security Number 6 Sex 7, Age (In vrs. last birthday) If Under TYear	If Under 24 Hrs.	8. Date of Birth	g Ri	rthplace (State or Foreign country)
	Funeral Director		577-34-4925 1™ 2□ F 82 Yrs. Months Days	Hours Min.	(Month, Day 08/16/1	1927 11	* .
		-	Usual Residence of Decedent				
	ow •		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
20	Mar)	ţ	MD Montgomery Silver Spring				1 ☐ Yes 2 ☒ No
A	128a	irec	10e. Street and Number 10f. Zip Code			10g. Citizen of What C	ountry?
	3a o	Funeral Director	3423 St. Leonard Court 20906			United Sta	ates
	ms 2	ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 10./ F  13. Was Decedent of His If Yes, specify Cuban,	spanic Origin? (Sp.	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	erican Indian, ite. etc.
9	or ite		1 Never Married 2 Married 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 No 1945 - 1 N	Specify:	, ,	Specify: W	
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2	within iene. <b>than</b> "	du	Elementary/Secondary (0-12) College (1-4or 5+)				
	filled wi Hygier sther th	S		10. Matharia Name	o (Eiret Middle	Medical Maiden Surname)	
nd	e d la le	Be	17. Father's Name (First, Middle, Last)  Albert Rappaport	Anna Zai		waster ourname,	
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	s 1 and 2 of Health item 27 I		Debra Whitcomb-Cousin 1204 Round Hou		Date	ndria, VA 2	
ore	of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	9)		200. Education Sty	n , o m, o tato
<u>E</u>	Pag ment ant: I ury c		4 □ Donation 5 □ Other (Specify) Mt. Lebanon Cem.	09/15	5/2009	Adelphi,	<u>Maryland</u>
Baltimore,	permit. Pages 1 Department of I Important: If ite any injury or ot		21. Signature of Funeral Service Licensee 22. Name and Address Inc. 1091	s of Facility Edy Rockvil	ward Sag le-Pike	gel Funera.	l Direction,
Ω.	9 2 E E 9						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
No.	Physician		Immediate Cause (Final disease or condition				1
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100	Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  b. Due to (or as a consequence of):  c. He pato renal Sync	wata	ilure	,	-
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8760,	cate be executed physician and the burial-transit	dical	d				
39	ing p	Mec	IF FEMALE:				de lle cons
Вох	leath certific aftending p	an/	23b. Was decedent pregnant  1  Live birth 2 Fetal death 3 Ectopic pregnancy	/		23d. Date of Month	Day Year
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ita	sician: The law certificate has t irector, page 2 s	Be (	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only	one)	
<b>-</b>	hysic nis ce I dire		1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	4 LI Nursing H		idence 6 Other (S	Specify)
0	ng Pl	Ë	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work	y at	28d. Describe	how injury occurred	
Si Oi	endii eath. or: A he fu	atic	2 Accident investigation	Yes 2□No	000 (	(D) A med Aleman in median	- Burnt Bouto Number
Division of Vital	r Att ter de irect	Certification: To	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		City or To	(Street and Number of wn, State)	Hurai Houle Number,
	ital o				a and due to the	e equipo(e) and manne	ar ac stated
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical	29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch	me, date and place pinion, death occi	e, and due to the urred at the time	e, date and place, and	due to the cause(s)
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تم	70 Vit	2	290. Signature and true or certifier	6802	G	mali	1/2009
	12			0300	0	0.1/1	1 1 2 2 3 .
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0122	MD 2002	2.2	
			Padmaja Bandi, MD 18101 Prince Philip Drive  31. Date filed (Month. Day, Year)  32. Registrar's Signature	orney,	בשט בעש	) 4	
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DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 250 A M Donis Ruzicka September 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Calvert 'alvert Memorial Prince Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 30 1935 9. Birthplace (State or Foreign Months Days Hours Washington DC 1 M 2 √ F 74 578<del>-</del>46-2972 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Calvert Maryland Huntingtown 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20639 3290 Ben Oak Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Specify: white 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 → No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Prep Cook Resturant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Albert Kerns Frances Lelia Cook 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene F. Reumont-daughter P.O. Box 874 Huntingtown MD 20639 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Sept. 17 2009 Cheltenham Maryland 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Rausch Funeral Home Brausc 4405 Broomes Is. Rd. Port Republic MD 20676 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Hypoxia disease or condition resulting in death) Due to (or as a consequence of) Meumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Pulmonory Disease Chronic Obstructive Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No 2. No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No

Physician /Medical **Examiner** 

permit. Pages 1 and 2 s Department of Health at Important: If Item 27 is any injury or other trau once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"naturai", or items 23a or 28a-f show idical Examiner must be notified at

the Medical

Director

Funeral

Completed by

Be

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2 should be filed within 72 hours after death with the Maryland n and Mental Hyglene.
Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

Examiner burial-trar

death certificate be execu ed by the attending physician detached for use as the buria signed by the cate has been signated based by certificate has funeral director, this After death.

Physician/Medical þ Completed Be

27. Manner of Death

1 Natural 2 ☐ Accident

3 ☐ Suicide

4 | Homicide

5 ☐ Pending investigation

6 Could not be determined

after death filled in by the To the Hospital of within 24 hours at To the Funeral D

Certification: To

dew

State Registrar

Medical

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

D67594

Prince Frederick, MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

September

14,2009

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

100 Hospital

32. Registra s Signature

Chery Hepp, 31. Date filed (Month, Day, Year) SFP 16 2009

Certificate of Death

2. Date of Death

3. Time of Death

2:30

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 XYes 2 ☐ No

Pennsylvania

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

Metropolitan Police

20c. Location - City or Town, State

Department

USA

Prince George's

Race - American Indian, Black, White, etc.

White

РМ

1. Decedent's Name (First, Middle, Last)

**Physician** 

9/14/2009 Cheltenham, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 2**X** No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 9/6/2009 D0012962 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Reginal Hospital, Laurel, MD 32. Registrar's Signature **ORIGINAL** 

State

Zorayda Lee-Llacer, M.D.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1052 PM Day Ye ar **Physician** Systember 10 2009 Margaret Irene Rosato /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Singi Mospital of Bultimore Baltimore City N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☐XF 173-30-0631 70 Director Feb. 26,1939 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experient must be notified at 1 ☐Yes 2 No Funeral Director MD Talbot. Sherwood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6800 Tilghman Island Road 21665 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Therapist Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell Wilson Dorothy Whisler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edward J. Rosato / spouse 6800 Tilghman Island Rd. Sherwood, MD 21665 of Health mpor ant; If item 27 ny in ury or other tr altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 9/14/2009 Bayview Cremaroty Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 23a. Part. Enter the stease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, brock, or heart failure. List only one cause on each line. Acute Myocardial Infarction Immediate Cause (Final days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a y, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of be executed Due to (or as a consequence of): burial physician the burial Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy for Month Day 5 Other (specify). P.0. the ģ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ splenectory, gastrectory 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an adeno cate has by page 2 s certificate 1 □Yes 2 □No Hospital or Attending Physician: TP 24 hours after death. Funeral Director; After this certificate (ety filled in by the funeral director, pag 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manufer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Shaw Posecto

Narard

atient

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MARTIN KUBIN, MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOSPITAL OF BALTIMORE SINAL

29c. License number 125-000 29d. Date signed (Month, Day, Year)

September 10, 2009

**Physicia** Medical Examir

> **Funeral** Director

> > any

Completed

hours after death with the Maryland

Jose H. Perez-Sir

ne		I <b>ndelible Ink. Ensure All Co</b> partment of Health and Menta ertificate of Death		05 3137
ı/ er	1. Decedent's Name (First, Middle,Last)  Jose Hector Perez	Simental	2. Date of Death  Month Day Year September 10, 2009	3. Time of Death 2056 hrs
	4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center	4b. City, Town, or Location of I Cheverly	Death 4c. County of De. Prince Geor	
	none _{1×M 2} 35	. last birthday) If Under 1 Year If Under 2 Months Days Hours		Birthplace (State or eignMexico
5	MD Prince George's	ty, Town or Location Hyattsville		10d. Inside City Limits 1 Yes 2 X No
		10f. Zip Code 20784	10g. Citizen of What C	•
/ runerai		If Yes, specify Cuban, Mexican, F		white White

16a. Decedent's Usual Occupation (Give kind of work done

during most of working life. DO NDT use retired)

Be 19a. Informant's Name/Relationship (Type, Print ) (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ Lourdes Perez/Sister Jefferson Street Hyattsville, Md20784 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State Nayarit, Mexico Municipal Cemeter 10/3/2009 Othe ure of Funeral Service PHILIP AND RINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring,Md20910

Laborer

Physician /Medical xaminer

and

signed by the attending physician be detached for use as the burial

the Hospital or Attending Physician: The law requires that the death certificate behin 24 hours after death. Division of Vital Records, P.O. Box 68760,

this certificate has been

After

Director:

within 24 hours at To the Funeral D

2

Physician/Medical

ð

Completed page 2 should

Be

2

Certification:

Medical

2 Accident

permit Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Baltimore, MD 21215-0036

> failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Examiner

> > UNPENDED

past 12 months?

IF FEMALE:

a. Multiple Injuries Due to (or as a consequence of):

AMENDED

230

1

15. Decedent's Education (Specify only highest grade completed)

Perez

23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

Approximate Interval Between Onset and Death

16b. Kind of Business/Industry

18. Mother's Name (First, Middle, Maiden Surname)

Simental

Antonia

Construction

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

12

Trinidad

Due to (or as a consequence of): Due to (or as a consequence of)

College (1-4 or 5+)

. If yes, outcome of pregnand	y			
Live birth	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Fetal death	3	Ectopic pregnan
Pregnant at time of death	-	(016)		

псу Other (Specify)

26.Place of Death (Check only one)

23d. Date of delivery Day Year

4 Yes 2 No 9 Unknown 9 Unknown

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 ✔	No 3 Probably 4 Unknown
24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of

1 🗸 Yes

2 No

23e. Did tobacco use contribute to the cause of death?

25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 1 V Yes 27. Manner of Death 28a. Date of Injury Sep 10, 2009 Natural

Pending

Investigation

Other₄ DOA 28c. Injury at Work? 28b. Time of Injury 2006 hrs Yes 2 V No

Nursing Home 5 28d. Describe how injury occurred Pedestrian struck by vehicle

No

✔ Yes 2

3 6 Could not be Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street

28f. Location (Street and Number or Rural Route Number, City or Town, State) W/B Route 450 , Riverdale , MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one and manner stated 29b

31. Date filed (Month, Day, Year) 2009

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) September 11, 2009

ame and address of person who completed cause of death (Item 23a) Laron Locke MD.

Assistant Medical Examiner

. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

State Registrar

ORIGINAL

OCME

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death C 13,2009 September David Schreiber 1:15 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bedford Court Assisted Living Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1⊠M 2□ F 053-07-2781 New York 12/31/1919 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits tX Yes 2 No Montgomery Silver Spring

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination ust be notified at

Baltimore, Maryland 21215-0036

Physician

/Medical

10a. State

MD

tor

Examiner

**Funeral** 

Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director name?

Division of Vital Records, P.O. Box 68760

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Ĕ	10e. Street and Number		10f. Zip Code			10g. Citizen of What Country?						
ral	3700 International Drive #254		20906	5		USA						
Be Completed by Funeral Dire	11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?  1 □ Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		13. Was Decedent of Hi If Yes, specify Cuba		? (Specify Yes or Nuerto Rican, etc.)							
d b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: WWII	-	1 □Yes 2 v No	Specify:		Specify: Wh	nite					
ete	15. Decedent's Education (Specify only highest grade completed)	10	ecedent's Usual Occupa Give kind of work done of	lurina most of	working	16b. K	ind of Business	/Industry				
Somp	Elementary/Secondary (0-12) College (1-4or 5+)	"	fe. DO NOT use retired,  Owner	,		Shoe Retail						
e (	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)											
To 8	Samuel Schreiber			Fanni	e "unknor	wn''						
	19a. Informant's Name/Relationship (Type. Print)	19b. N	lailing Address (Street a	and Number o	r Rural Route Num	ber, City o	or Town, State.	Zip Code)				
	Faye Summers / daughter		4 Jefferson									
	20a. Method of Disposition 20b. Pl	ace of D	isposition (Name of crematory or other place		Date	20c. Lo	ocation - City or	Town, State				
			crematory or other place Mem. Garder	e) 15 : 09	/15/09		ney, MI					
	od objective of 5	Can	22. Name and Addres			01						
	21. Signature of Fundam Service Licensee M01163		Danzansky 1170 Rocky	-Goldb	erg Memo	rial	Chapel-	Inc				
	232 Part T Enter the disease, or complications that caused the death	Do not	anter the made of duin	ville r	rice ROC	KVIII	Le, MD					
	snock, or heart failure. List only one cause on each line.	. Do not	enter the mode of dying	g, such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death				
	Immediate Cause (Final disease or condition Park in Fon Licease											
disease or condition resulting in death)  a. Parkinson Disease  Due to (or as a consequence of):												
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listedse or i july that influsted events c											
ner												
ami	Cause (Disease or Figury that initiated events c.											
Ä	resulting in death) Last Due to (or as a consequ	ence of):					·					
Sequentially ist conditions   Due to (or as a consequence of):												
S I I STANIS												
<u> </u>	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant				23d. Date of delivery							
S	in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal  1 ☐ Yes 2 ☐ No  4 ☐ Pregnant at time of de		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/	Month Day Year							
hys	9 Unknown											
Σ	Part II. Other significant conditions contributing to death but not result					tobacco i	use contribute t	o the cause of death?				
ed	Arortic Valve Replacement	Co	ronary Arte	ery Dis	seasc ₁□	Yes 2	⊠No 3∏P	Probably 4 Unknown				
plet	Cerebrovascular Accident	Atri	al Fibrilla	ation	24a. Wa		24b. Were a	utopsy findings available				
E	Chronic Lymphocytic Leukemia				per	opsy formed?	death?	completion of cause of				
BeC	25. Was case referred to medical			26 Place of	1 ☐ Yes Death (Check only		1 LIYe:	s 2 <b>x</b> No				
To B	examiner? 1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ I	=R/Outos	othe		ng Home 5 ☐ Res		C [] (th (0)					
n:	27. Manner of Death 28a. Date of Injury	28b. Tim			28d. Describe			ecify)				
iti	1 X Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Inju		? Yes 2 □ No		11011 111101	y occurred					
lica	3 Suicide 6 Could not be 28e Place of Injury - At hor	ne. farm			28f Location	(Street ar	nd Number or E	Tural Route Number,				
erti	4 Homicide determined building, etc. (Specify	)	on oor, ractory, onloc		City or To	wn, State	e)	idiai nodie Number,				
<u>ء</u>	29a. Certifier 1区 Certifying Physician: To the best of my know	vledae. o	leath occurred at the tim	ne, date and n	lace, and due to th	e cause/s	) and manner	as stated				
Medical Certificatio	(Check only one) 2 Medical Examiner: On the basis of examinat and manner stated.	ion and/o	or investigation, in my or	pinion, death	occurred at the time	e, date and	d place, and du	e to the cause(s)				
Me	29b. Signature and title of fertifier		29c. License	number		29d. Da	te signed (Mon	th, Day, Year)				
	h hands		D1872	26				14, 2009				
	30. Name and address of person who completed cause of death (Item	23a) /Tu	ne Print)									
		-ua) (1)	po, 1 11111)									

DHMH 17 Rev 1/2001

State

Registrar

Arthur Schoengold, MD

SEP 16 2009

31. Date filed (Month, Day, Year)

10

18111 Prince Philip Drive Olney, MD 20832

John Michael Sie		Sh St I- For State	ate of Maryl		epartmen C <i>ertificate</i>			Mental			NO 0100	
Physicia	_	Registrar 1. Decedent's Name (First, Midd	lle.Last)		Jertincate	- OI Dea			2. Date of Dea	eg. No. th	3. Time of Death	
Physicia Medical Examir	117	Michael		Т.	h		Se	ndish	Month September	Day Year er 18, 2009	2302 hrs	
		4a. Facility Name (if not institution	on, give street and n		hn	4b. City		ocation of De		4c. County of Dea	ath	
		Anne Arundel Medica	l Center			Ann	apolis			Anne Arunde	el	
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthda	ay) If Un	der 1 Year			rth(MM/DD/YYYY) 9. E		
Director	- 1	216-68-8147	1 X M 2 F		52	Yrs. Mon	ths Days	Hours	Min. Oct.	20,56 Fore	Country)Maryland	
	- 1	Usual Residence of Decedent		l								
any		10a. State 10b. County		10c.	City, Town or	Location					10d. Inside City Limits	
and show	5	Maryland Ann	Arundel		Annapo	lis					1 XYes 2 No	
4aryla 28a-f	ë	10e. Street and Number		<u> </u>		10f. Z	ip Code			l0g. Citizen of What Co	ountry?	
Sa or	히	1600 Whitefor	rd Pl				210	37		USA		
1502 y death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral Director	11. Manital Status		ecedent Ever Forces?	in U.S. 1				( Specify Yes or No erto Rican, etc.)	14. Race - Am White, etc.	erican Indian, Black,	
death or ite	إج	1 X Never Married 2 N	1 Yes	$_{2}\!\mathrm{X}$	No		_		orto raddii, otdiy			
rafter	2		vorced If Yes, Give Your Dates:				2 <b>X</b> No			Specify: W	hite	
hour natu Exan		15. Decedent's Education (Spe		(1-4 or 5+)		cedent's Usu ring most of v			d of work done e retired)	16b. Kind of Busines	s/iridustry	
36 iin 72 han '	Be	Elementary/Secondary (0-12)	College	(1-4 01 5+)	CI	illed	3 T-	bor		Constru	ction	
5-0036 led within 7 Hygiene. other than	Completed	12 17. Father's Name (First, Middle	e, Last)		27	TITLEC			lame (First, Middle,		CC1011	
215 be file ntal Hy rked o	Be	Iotto		J.	Ser	ndish		Edna		L.	Hager	
213 ould b	2	19a. Informant's Name/Relation	ship (Type, Print)				ss (Stree	t and Number	r or Rural Route Nu	mber, City or Town, St	ate, Zip Code)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Edna Sendis	h/ Mothe		263	35 Pir	newoo	od Dr.	.,Waldor	f,Maryla		
Te, l l and l'Heal l'Heal		20a. Method of Disposition  1 Burial 2 XCrematic	6 T B		20b. Place of I	Disposition (Ny or other place		netery,	Date	20c. Location - City	or Town, State	
altimore, mit. Pages I a ppartment of He pportant: If ite		4 Donation 5 Other S		from State	•	polit			2/22/200	)9 Alexan	dria Va	
altir mit. I partm porta	- 1	21. Signature of Funeral Service		\	110010	44.11						
<b>8</b> 8 8 <b>8</b>		Slay o He	Sled	)	191	Adams	Fur	neral	HomePA,	Aquasco,	Maryland	
Physician	(	23a. Part I. Enter the disease, of failure. List only one caus	or complications that e on each line.	caused the	death. Do not e	enter the mod	le of dying,	such as card	iac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and	
/Medical Txaminer		Immediate Cause (Final diseas	IIven o w	tensiv	e athe	roscle	rotic	cardi	Lovascula	r disease	Death	
, Adminor		or condition resulting in death)	Due to (or as	a conseque	nce of):							
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	nce of):							
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sit sd	xai	events resulting in death) Last  Due to (or as a consequence of):										
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, P.O. Box 6876 fres that the death certificate signed by the attending phy be detached for use as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in	the	s, outcome o e birth	r pregnancy 2	Fetal dea	ath 3	Ectopic p	regnancy	Month	Day Year	
X 6 th cert	icia	past 12 months?	1 '	gnant at time		Other (S	Specify)					
Box te death c the atten ted for us	hys	1 Yes 2 No 9 U	19	nown					loo pid		e to the cause of death?	
P.O.	by P	Part II. Other significant cond		•	_			given in Part			Probably 4 V Unknown	
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n of Vital Records, ing Physician: The law require After this certificate has been si uneral director, page 2 should b	70	1 ✓ Yes 2 No	Hospital: 1	-	2 🗸 ER/Out		DOA		Nursing Home 5		Other:	
n of V ding Phy. After th funeral		27. Manner of Death  1 X Natural 5 Death		ite of Injury nth, Day,Year)	28b. Ti	me of Injury	1	iry at Work? Yes 2 N		e how injury occurred		
Sior Attend r death. ector: by the	atic		nding restigation							(Oter at an d Normal and	- Dural Davida Numbar City	
Division spital or Attendii tours after death.	Certification:		uld not be		- At home, fan	m, street, fac	tory, office	building, etc.	or Town		r Rural Route Number, City	
Dspita neral y fille		4 Homicide					No o Post of			uses(a) and manner an	stated	
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	ica	Chook anti-	Physician: To the t caminer:On the bas	sest of my kn is of examina	iowiedge, deat ation and/or in	n occurred at vestigation, ir	tne time, c my opinio	ate and place n, death occu	e, and due to the ca rred at the time, da	use(s) and manner as te and place, and due	to the cause(s)	
Sign Miles	Medical	29b. Signature and title of certi	and manne	r stated.			29c. Licen				(Month, Day, Year)	
		1.10. 1		181	-		O.C	M.E.		September 19	9, 2009	
		30. Name and address of person	asset 4	ause of death	h (Item 23a)					1		
NR		Melissa Brassell, MD				111 Penn	Street, I	Baltimore,	MD 21201			
S	ate			Registrar's S		par						
Regis		SEP &	2 4 2009	Denews	U po.	A mar	`					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Day 11 Physician/ 2009 Mary A. Sann 08:55 Αм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel South River Health & Rehab. Center Edgewater If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth Funeral Hours 0*577307*1*9*41 Director 217-38-5409 68 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Anne Arundel Edgewater Maryland 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 21037 144 Washington Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 4. Race - American Indian, Armed Forces? 1 Pyes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural" 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home permit. Page 1 and 2 should be flied with Department of Health and Mental Hygier Important: If item 27 is marked other tl any injury or other traumatic event, the once. Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret L. Beazley Melbourne Bonang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Virginia L. Weems/Sister 458 Waterville Road, Skowhegan, ME 04976 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/12/2009 Edgewater, Maryland Kalas Crematory Se e in ensee 22. Name and Address of Facility George F. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final obstructive Physician/ hranic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner This to for as a curaculumoust attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown the detached Hnknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ■ Yes 2 □ No 3 □ Probably 4 □ Unknown Division of Vital Records, Corpumonale Completed 24b. Were autopsy findings available prior to completion of cause of Breast 24a, Was an HILLOTY has autonsy death? 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Yes 2 ☑ No Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

5851-

31. Date filed (Month, Day, Year) SEP 14

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deale

2009

Churchton

29c. License number

Rd.

D 50653

GYAN C-SURANA

29d. Date signed (Month. Day, Year)

2075)

9-11-

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** SIMMONS GARY SEPTEMBER 12 2009 4:14 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL If Under Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 ☐ F 41 WASHINGTON, DC Director 578-08-1371 MAY 19 1968 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Director FT. WASHINGTON PRINCE GEORGE'S MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20744 7101 CHERRYFIELD ROAD by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No ARMY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 X Married BLACK Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE DISPATCHER 12TH permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygin Important; If item 27 is marked other any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHIRLEY HAWKINS DONALD SIMMONS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CHERRYFIELD ROAD FT. WASHINGTON, MARYLAND 20744 FLORETTE SIMMONS/WIFE Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHELTENHAM, MARYLAND MD VETERANS CEMETERY 9/21/2009 11. Signal re of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): physician sthe burial Box 68760. Physician/Medical attending pl for use as tl IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a P.O. 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 1 ☐Yes 2 ☐No 1 ☐ Yes 2 🖼 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2<del>□</del>1√0 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) To the Funeral Director: After th completely filled in by the funeral 27. Man of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Division 5 ☐ Pending investigation death. 1 ☐Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide after Hospital within 24 hours a To the Funeral C 29a. Certifier Certifying ysician: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29b. Signature a se of death (Item 23a) (Type, Print) Name and address of pers

DHMH 17 Rev 1/2001

State Registrar RE

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year  $P^{M}$ 9/15/2009 6:37 Annette Frances Duhame Seeley 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Washington Adventist Hospital Montgomery Takoma Park Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day) Months Days Hours Min 1 □ M 2 🕅 F 579-56-3597 6/14/1923 Montana 86 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Prince George's Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20782 U.S.A. 3541 Madison Place 12. Was Decedent Ever In U.S. Armed Forces? 1 Myes 2 □ No Navy If Yes, Give Year or Dates: 1943–46 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify White 3 Widowed 4 X Divorced 16b, Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nora Margaret Fogarty Ralph Louis Duhame 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3541 Madison Place, Hyattsville, MD Sylvia Seeley / Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/21/2009 Crownsville, Maryland 4 □ Donation 5 □ Other (Specify) MD Veterans Cemetery 22. Name and Address of Facility 4739 Baltimore Avenue 21. Signature of Funeral Service Licensee Gasch's Funeral Home, P.A. Hyattsville, MD 20781 KAY Kagans 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each live? Approximate Interval Between Onset and Death not enter the mode of ming, such as car liac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a sequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Ye ar Day in the past 12 months? 1 □Yes 2 🖾 No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 1 ☐Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

tral", or items 23a or 28a-f show (Examiner must be notified at

"natural", or

er than "nature

alth and Mental Hygiene.

27 is marked other than "
r traumatic event, the Me

Health a

Department of Health Important: If item 27 any injury or other to once.

Director

Funeral

9

Completed

Be

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the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

and attending physician efor use as the burial signed by t icate has been signated by page 2 should b certificate this After 1 24 hours after death.

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical ð Completed Be Certification: To

Medical thin 2

State

Registrar

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5+1	
3	

IF FEMALE

Dr. Nasreen Kango, 7701 Carroll Avenue, Takoma Park, MD 20912 31. Date filed (Month, Day, Year) 1 8 2009

29b. Signature and title of certifie

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Sulcide

29a, Certifiei

(Chec one)

4 Homicide

32. Registrar's Signature

28a. Date of Injury (Month, Day, Year)

and manner stated.

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 ☐ Could not be

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Ye ar **Physician** Jean Bell Tison September 12, 2009 3:37 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛣 F Director 30, 1927 South Carolina 251-32-0679 Jan. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shovevent, the Madical Examiner must be notified at Montgomery Maryland Silver Spring 1 □Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1108 Ruppert Road 20903 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2√☐No Specify δ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home ortant: If item 27 is marked other injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William J. Bell 2 Leola McAlhany 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carey C. Tison/Husband 1108 Ruppert Road, Silver Spring, MD 20903 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If itel any injury or ott Sept. 2009 15, 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Sign turn of Funeral Service Lic 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or shock, or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) orona /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mo Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural

be executed Box 68760, P.O. Records, Division of Vital

with the Maryland

72 hours after

2 should be fi

Saltimore, Maryland 21215-0036

28a-f show

physician and s the burial-trans or Attending Physician: The law requires that the death certificate attending p as been signed by the should be detached has e 2 s certificate ha this certific al director, Certification: To After the funeral 5 Pending investigation I hours after death.

uneral Director: A
ely filled in by the fu 1 ☐ Yes death. 2 🗌 No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

29c. License number 29b. Signature and title of certif 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll 20912 hi ames Davic 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 16 2009

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** EDWARD NARVEL TAYLOR SEPT 2009 5:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Months Year) **Director** 577-58-9790 62 WASH. D.C. APRIL Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho 1 XYes 2 ☐ No Director MD. PRINCE GEORGES CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6601 SQUIREMAN CT. 20735 Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2X No If Yes, Give 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 3 Widowed 4 Divorced BLACK Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **PRESSMAN** PRINTING other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked of traumatic even ပ HAROLD TAYLOR AURTHELAH SMITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Department of Health Important: If item 27 any Injury or other tr PATRICIA GALLOWAY/SISTER 6601 SQUIREMAN CT., CLINTON,  $MD_{\bullet}$ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 9-15-2009 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 21. Signature of Funeral Service Ligensee CHAMBERS FUNERAL HOME & CREMATORIUM, P. A CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the ceath certificate be executed physician and the burial-transit resulting in death) Last Due to (or as Box 68760 Physician/Medical attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 0 certificate has been signed by the rector, page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation s after dea...
seral Director: Afiled in by the 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** <u>06</u>:55a [™] 2009 SEPT HAROLD THOMPSON 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton Birthplace (State or Foreign Country)
 SC If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 29, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 13 M 2 □ F 91 1918 218-03-5826 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show r than "natural", or items 23a or 28a-f sho the Medical Examiner nust be notified at 1 ☐ Yes 2X No Director MD Prince Georges Temple Hills with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20746 USA 2302 Foster Pl. by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Styles 2 □ No If Yes, Give 1944— Year or Dates: 1964 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, tre Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Oceanagraphics Equipment Specialist lyr. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Thompson James W. Thompson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Warren A. Thompson - Son 2302 Foster Pl. Temple Hills, Md. 20748 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-13-2009 Arlington, VA. 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CAMMINE Arry Mymu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has t rector, page 2 s autopsy performed? (es 2 No 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2.1≦No 2 ER/Outpatient 3 □ DOA 1 🔲 Inpatient Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation ours after death. Ieral Director: Aff filled in by the fun 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated within 2 To the 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sikh DIL State

DHMH 17 Rev 1/2001

Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 2009 0200 Thomas Vivginia 09 16 4c. County of Death 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) chever Prince 600 rgc Hospital Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 9-23-7. Age (In yrs. last birthday) 5. Social Security Number Days Hours 1 □ M 25 F 578-22-2766 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 15 Yes 2 □ No Upper marlboro Prince Georges MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 10910 Dubs Court USA 20774 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2V No Specify: Black Specify: \$ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government Elementary/Secondary (0-12) College (1-4or 5+) Branch Head 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John christine Allen 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deloves Thompson/dougher 10910 Dubs Court Upper Mariboro, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition maryland National Cemetary 9/25/09 Laurel, mo urial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility 21. Signature of Funeral Service Licensee Bianchi 814 upshur St NW Wash, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): anemio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the ceuse of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 Tyes 2 No NON -TRAUMATIC 25. Was case referred to medical examiner? 1 Yes 2 □ No 26. Place of Death (Check only one)

**Physician** /Medical Examinat

Physician

/Medical

Examiner

**Funeral** 

Director

r then "netural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or ite any Injury or other traumstic event, the Medical Examina

3altimore, Maryland 21215-0020

death with the Maryland

anding physician and use as the burial-transit The law requires that the death certificate be executed hed by the a this certificate has been signed by ral director, page 2 should be detac or Attending Physician:

after death. 24 hours

Physician/Medical Examiner ð Completed Be 2 Certification:

edicai

To the Hospl within 24 hou To the Funer completely fil

Hospital

Division of Vital Records, P.O. Box 68760,

State Registrar 29b. Signature and title of certifier

27. Manner of Death

1 Alatural

3 Suicide 4 ☐ Homicide

29a. Certifier

2 Accident

Hospital:

5 Pending investigation

6 Could not be determined

Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

and address of person who completed cause of death (Item 23a) (Type, Print)
To mee A Heras Prince George Hospital

31. Date filed (Month

32. Registrar's Signature

Date of Injury (Month, Day Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ White Jacqueline LaRue Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Days Min (Month, Day, Year) 1 □ M 2 🖾 F Hours Yrs **Director** 213-40-4934 66 1942 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No WV Morgan Great Cacapon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4070 Woodmont Rd. 25422 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ed other than "natural", event, the Medical Exa Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 lith and Mental Hygiene. ?7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Stewart Snyder Eileen Devilbiss traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. James R. White, Sr./Husband 4070 Woodmont Rd., Great Cacapon, WV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 9/25/2009 Resthaven Crematory Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S-Man 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Jessis secondo Medical o (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-tran that initiated events resulting in death) Last or as a consequence of: Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ Unknown g Unknown signed by t I be detach Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🎾 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural Accident Suicide 28d. Describe how injury occurred the Hospital or Attending injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ast antietamst Hagerstown Ka ourosia

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Box 68760

Division of Vital

09-07420 Richard Wagner Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

chard Wagner	1	State of Maryland / Department of Health and Mental H - For State Certificate of Death		2 O	09 3139					
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Deat	ng. Noh Day Year	3. Time of Death					
edical Exami	ner	RICHARD ROBERT WAGNER	Month Septembe		1920 hrs					
		4a. Facility Name (if not institution, give street and number)  Atlantic General Hospital  Berlin	h	4c. County of Deat Worcester						
Funanci		Atlantic General Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	s. 8. Date of Birt	th(MM/DD/YYYY) 9. Bi	rthplace (State or					
Funeral Director		185-36-8767 1 NM 2 F 58 Yrs. Months Days Hours Min	09/2	0/1951 Forei	gn puntry) RI					
	ŀ	Usual Residence of Decedent			Land topide City Limits					
* any		10a. State 10b. County 10c. City, Town or Location			10d. tnside City Limits  1 Yes 2 No					
daryland 28a-f show 1 at once.	후	MD MONTGOMERY BOYDS  10e Street and Number 10f. Zip Code	11	0g. Citizen of What Cou						
e Mary or 28a	Director	10e. Street and Number 21111 SLIDELL ROAD 20841		USA						
with th s 23a		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No	- 14. Race - Ame	rican Indian, Black,					
death r	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerl	to Rican, etc.)	White, etc.	TME					
after	P F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify.  15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	f work done	Specify: WH						
hours "natur		College (1-4 or 5+)	etired)							
5-0036 led within 72 tygiene. other than the Medical	Completed	RENOVATION CARPENT	'ER 	CONSTRU	CTION					
ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than natic event, the Medica		17. Fattlet 5 Name (1 115t, Middle, Edst)		Maiden Surname)						
2121 ould be fill Mental H marked ic event,	<b>m</b>									
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	٩	MARCIA WAGNER / SPOUSE 21111 SLIDELL RD.			841					
Baltimore, ML permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traum	ı	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City	or Town, State					
MOF Pages ent of int: If		1 Nation 2 Cremation 3 Removal from State BOTHS PRESBYTERIAN OHURCH CEMETERY	9/28/0	9 BOYDS	, MD					
Baltimore, bermit. Pages I an Department of Hee Important: If ite	ı	21. Signature of uner Service Licensee  22. Name and Address of Facility HILTON FUNERAL	HOME		20020					
		P.O. BOX 86. B  Z3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	ARNESV	TITE MD rest, shock, or heart	20838 Approximate Interval					
Physician /Medical		failure. List only one cause on each line.			Between Onset and Death					
caminer		Immediate Cause (Final disease or condition resulting in death)  a Drowning  Due to (or as a consequence of):								
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	miner	If any, leading to immediate cause. Enter Underlying Cause Ulusease or Injury that initiated								
ed sit	Exar	events resulting in death) Last  Due to (or as a consequence of):								
60, te be executed ysician and burial - transit	ledical	UNPENDED AMENDED								
60, ate be ohysici ne buri	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv						
Sox 6876( leath certificate e attending phy for use as the b	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	gnancy	Month	Day Year					
Box 6876 e death certificat the attending phied for use as the	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	Unknown							
P.O.   es that the gned by t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute	robably 4 Unknown					
S, P.C uires that an signed I	Completed by				autopsy findings available					
cords law requi has been 2 should	ple		per	formed? death						
tal Rectian: The certificate ector, page	S	25. Was case referred to medical 26.Place of Death (Che	1 Yes	2 No 1 🗸	Yes 2 No					
'ital sician: is certi lirector	Be	examiner? Hospital: 4 Innation: 2 FR/Outpatient 3 DOA Other4 Nu	rsing Home 5	Residence 6 0	ther:					
of Vital Rec ling Physician: The After this certificate funeral director, page	7: To	27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?		e how injury occurred owned in ocean						
ion tendin eath tor: A	atio	Assident Investigation Sep 21, 2009 1908 hrs								
Division of Vital Records, ral or attending Physician: The law requir rs after death all Director: After this certificate has been seled in by the funeral director, page 2 should	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town		Rural Route Number, City					
Ospital hours nuneral y filled		29a. Certifier	and due to the ca	use(s) and manner as	stated.					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, da	te and place, and due t	o the cause(s)					
To To	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed						
		MM O.C.M.E.		September 22	2, 20 <del>09</del> 					
5 V		30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201							
	tate	22 Phietrar's Signature								
Regis	tate strar	SEU 311 2000 / 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		OCIME						

			For State Registrar	State of	of Marylan		artment of F rtificate of		nd Mental Hy	rgiene Reg. No. 🤈	0110	31393
	Physici		1. Decedent's Name (First, Mid	dle, Last)  Doris	Winer				2. Date of De Month Septembe	Day	Year 2009	3. Time of Death 8:38 p M
*.	/Medio Examin		4a. Facility Name (If not institut				4b. City, Town, o	r Location of [	1 2		unty of Death	
فمريد	LAGIIIII		Calvary Car	e Group Home	2			Silver S	Spring		Montge	omery
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		If Under 24		rth	9. Birthp	place (State or Foreign
	Director		579-20-8894	1 □ M 2 <b>K</b> F	83	Yrs.	Month's Days	Hours	March 6	, 1926		rginia
	pr ,		Usual Residence of Decedent									Od India Ob Links
	srylar show	<u>.</u>	10a. State 10b. Coun	У	10c. Cit	y, Town or Lo	cation				Τ'	0d. Inside City Limits  1 □Yes 2X No
	8a-f	Director		Arundel				Dunkirk	c			
	ith th	ä	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cour	<i>'</i>
	ath v	<u>ra</u>	6319	Johns Lane				20754			U.S.	
36	within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show the fludical Examinum must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marital Marital American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American American Ame	Armed F 1 ☐ Yes If Yes, G	2 📉 No iive	i	Was Decedent of F If Yes, specify Cuba 1 □Yes 2 🏿 No	IIspanic Originan, Mexican, F Specify:	n? (Specify Yes or No Puerto Rican, etc.)		Race - Americ Black, White, ecify:	etc.
21215-0036	houn fural	다 다	3 Widowed 4 Divorce		Dates:	160 Dooo	dent's Heuri Occur	ation		16b Kind	of Business/In	White
15	n 72 "nat	Completed	(Specify only high	ent's Education lest grade completed	)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most o	f working	100. Killa	of business/in	udstry
12	within iene. <b>than</b>	Ę.	Elementary/Secondary (0-12)	College (	(1-4or 5+)	1	Secre	•		F	rivate :	Industry
	Hyg ther nt, t		17. Father's Name (First, Middle	l ə, Last)					Name (First, Middle			
an		o Be		Max Co	ohen				Rosa	Abrahms		
Z	s 1 and 2 should be f f Health and Mental item 27 is marked o other traumatic eve	ျ	19a. Informant's Name/Relation		ж	19b. Mailir	na Address (Street	and Number	or Rural Route Numb		wn. State. Zir	Code)
<b>≥</b>	tra tra		Diane Citro	, , , , ,		4			rk, Maryland	•	, , , , , , , , , , , , , , , , , , , ,	,
ē,	1 and 2 Health tem 27 i		20a. Method of Disposition	Daughter	20b. F	Place of Dispo	sition (Name of	-	Date		ion - City or To	own, State
Baltimore, Maryland	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other Once.		1 🗷 Burial 🗷 🗆 Cremation		State	•	natory`or other plac	· .	20/27/2000	P-11-	Chamab	Vizzinia
Ħ	artme		4 □ Donation 5 □ Other.	- 1 - /		40	Memorial Ga  2. Name and Addre		09/17/2009	raiis	church,	Virginia
Ba	Department of the series		21. Signature of Luteral Service	male	M0076	′/ H <del>i</del>	ines-Rinald	i Funera	al Home, Inc Avenue, Sil	· ··om Comi	na Marr	rland 2000/
	Physician /Medical Examiner		23a. Part 1. Enter the disease shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	st only one cause on a. A.	caused the deat each line. Lzheimer's (or as a conseq	Disease		ng, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death <b>Years</b>
8760,	icate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	C	o (or as a conseq	,						
P.O. Box 687	the death certif y the attending ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live 4 ☐ Preţ 9 ☐ Unk		death 3 death 5	☐ Ectopic pregnand ☐ Other (specify) _				. Date of deliv	Day Year
	requires that seen signed b nould be deta	ρ	Part II. Other significant condi	tions contributing to o	death but not res	ulting in the ur	nderlying cause giv	en in Part I.				he cause of death?
l Rec	The law ate has b page 2 sl	e Completed	25. Was case referred to medic	al				26. Place o	24a. Was	s an 2 ppsy ormed? 2 No	4b. Were auto	opsy findings available ompletion of cause of
>	ys is	.0 B	examiner? 1 ☐ Yes 2 🗷 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nurs	ing Home 5 ☐ Res	sidence 6 🗷	Other (Speci	(fy) Group Home
	Attending Ph r death. ector: After th by the funeral	ation: T	27. Manner of Death  1 🛣 Natural 5 🗌 Pend 2 🔲 Accident inves		e of Injury nth, Day, Year)	28b. Time of Injury	Wor	-	28d. Describe			,,
5	tal or Atters after dear all Directored in by the	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	d not be mined 28e. Place build	e of Injury - At ho ding, etc. <i>(Specit</i>	ome, farm, str	eet, factory, office		28f. Location City or To	(Street and Nown, State)	lumber or Rur	al Route Number,
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical		ring Physician: To the and mar								
	<b>To the</b> within 2 <b>To the</b> сотрlе	Σ	29b. Signature and title of certif	ier	1		29c. Licens	e number		29d. Date s	igned (Month,	Day, Year)
	12		121	Karo	ba	,	r	09834		Septer	mber 16,	2009
	L		30. Name and address of person	· ·					L			
			Barry M. Rosenb	aum, M.D., 3	720 Farra	gut Aven	ue, Kensing	gton, Ma	ryland 20895	·		
H	Sta Registr	100	31. Date filed (Month, Day, Yea	2009 Jen	Registrar's Signa	for	Med.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of M	aryland		rtment of F		R	eg. No. 2	115	3 - 3 3 4	
8	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month			Day Year		3. Time of Death	
400	/Medic		Gladys Irene Wiemann					Sept.					6:00 p M	
	Examin	er	4a. Facility Name (If not i		4b. City, Town, or Location of Death			4c. County of Death						
	All Marie		Renaissance Gardens at Riderwood Village  5. Social Security Number 6. Sex 7. Age (In yrs. last b					Silver Spring  irthday) If Under 1 Year If Under 24 Hrs.		Doto of Righ	Prince George's			
200	Funeral Director part show titled at		5. Social Security Number 137–36–1895	1	1 M 2 🔀 F 86 Yrs.			Months Days Hours Min.		(Month, Day, Sept. 21,	B. Date of Birth (Month, Day, Year) Sept. 21, 1922  9. Birthplace (Country) Massachu		ace (State or Foreign try) <b>chusetts</b>	
		Director	Usual Residence of Dece 10a. State 10b	. County							0d. Inside City Limits  1  Yes 2 No			
			Maryland Montgomery				Silver Spring							
	h with th		10e. Street and Number 604 Dale D	rive				10f. Zip Code	209		0g. Citizen of W <b>USA</b>	hat Coun	try?	
215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 3 ☑ Widowed 4 □		12. Was Decedent Armed Forces' 1 ☐ Yes <b>XX</b> If Yes, Give Year or Dates:	?		Was Decedent of H f Yes, specify Cuba I □ Yes 25 No		pecify Yes or No- to Rican, etc.)	Black	- America , White, a <b>White</b>	etc.	
		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-			5.)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/In				siness/Inc	lustry		
212	l with liene r thai	To Be Com	Elementary/Secondary	y (0-12)	College (1-4or	5+)	Real Estate Agent				Real Est	ate		
p	illed Hyg other ent, i		17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle			e, Maiden Surname)			
<u>a</u>	should be fand Mental I		William Whit	ford					Grace Rob	inson				
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygene. Important: If item 27 is marked other than any injury or other traumatic event, the Mence.		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  604 Dale Drive, Silver Spring, MD 20910								Code)			
Baltimore,			20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			ce	metery, crei	sition (Name of matory or other place in Cremator	Sept		20c. Location -			
Balti			21. Signature of Funeral Service (Joensee  22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901										901	
	The law requires that the death certificate be executed to the set of the attending physician and the best of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death											
-			Immediate Cause (Final disease or condition resulting in death)  a. ALZHEIMERS DEMENTIA  Due to (or as a consequence of):											
			Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury)	as a consequence of):										
, Ö			that initiated events C.			s a consequence of):								
68760,		edical		•	d									
Box		by Physician/M	IF FEMALE: 23b. Was decedent pregin the past 12 mon 1 □ Yes 2 ☑ No 9 □ Unknown	ths?	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 🗌 Fetal	death 3	Ectopic pregnanc Other (specify)	,		23d. Dati Moi	e of delive	ery Day Year	
ls, P.O			Part II. Other significant continuous continuous to the cause of the cause given in Part I.											
or Vital Records,	law requir as been si 2 should	Completed	osteoporosis					24a.			Was an autopsy findings available prior to completion of cause of			
tal R			poly myalgia rheumatica performed? death? 1 Yes 2/2 No 1 Yes 2 No											
Ξ	slcia certi	) Be	25. Was case referred to médical examiner?  1   Yes 2 No											
on or	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	tion: To	27. Manner of Death	Pending investigation	28a. Date of Inj (Month, D	a. Date of Injury (Month, Day Year)  28b. Time o Injury				28d. Describe how injury occu				
Division		Medical Certification:		Could not be determined	not be 290 Place of injury - At home form s			reet, factory, office 28f. Loc			ocation (Street and Number or Rural Route Number, ity or Town, State)			
			29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the within To the Youngle		29b. Signature and title of codifier 29c. License number 29d. Date signed								(Month,	Day, Year)		
	3			Sachelle alexion 1 ALEXION D44156							09/15/2009			
			29a. Certifier  (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32 Registrar's Signature  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature											
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DHMH 17 Rev 1/2001

SEP 16 2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09 20°0°9 М Burley 4:45p Cleatrice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Catonsville 1305 Middleford Road Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** (Month, Day, Days 1 ☐ M 2🗶 F Hours Min. 88 216-20-9177 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 XNo MD Baltimore Catonsville 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21228 U.S.A. 1305 Middleford Road Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: Completed 3X Widowed 4 ☐ Divorced Black Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Factory Seamstress 6th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josephine Peoples Robert Bond Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 Middleford Road Catonsville, Md 21228 Evelyn NeSmith-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Crownsville Vet Crownsville, Md 10/5/09 Donation 5 Other (Specify) 21. Sig 22. Name and Address of Facility
March F/H West
4300 Wabash Av atu eiof Funeral Service Licensee 21215 Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consec Examiner osteomy elitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to or as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): physician P.O. Box 68760 Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day Year Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ement's Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe death? certificate Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work? s after death. 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 30.2009

Registrar

DHMH 17 Rev 7/2009

State

3512 New

21218

e and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Schw

31. Date filed (Month, Day, Year)

09-07480 Shantel Brown

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ Month Day Yes 0322 hrs Medical Examiner Shantel Brown c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Raltimore Johns Hopkins Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Davs 3-27-1978 Country) MD Director 215-92-3696 2X F М Yrs 31 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iny 1 YYes 2 No or 28a-f show fied at once. Baltimore N/A MD with the Maryland Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number USA 21213 1632 Cliftview Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status White etc. Armed Forces 1 XNever Married 2 Married 2XSpecify: Black Yes ò 2 No specify: If Yes, Give Year Yes Widowed 4 Divorced hours after "natural", 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) unemployed ges 1 and 2 should be filed within 72 l Unemployed than " 21215-0036 N/A 12th grade marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tresia Bennett Be Kenroy Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) If item 27 is muther traumatic e Baltimore, MD Mannasota Avenue Balto, MD 21202 Kenroy L. Brown -Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Pages 1 ratment of 7 other ( 1XXBurial 2 Cremation 3 Removal from State 10-3-2009 Balto Co, MD Woodlawn Cemetery 4 Donation 5 Other Specify: 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee Avenue Balto, MD 21206 North 1101 Ε. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death Medical a. Multiple Sharp Force Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cauce (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be exect Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 2 past 12 months' Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 V No 3 Probably 4 Unknown ⋧ Completed Records, has been si 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes certificate h 26 Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ examiner? Nursing Home 5 DOA Residence 6 Inpatient 2 V ER/Outpatient 3 this 2 ٩ 1 V Yes After th 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Subject stabbed and cut Certification: Sep 23, 2009 0115 hrs Yes 2 V No Natural 1 Pending within 24 hours after death. To the Funeral Director; completely filled in by the Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 2100 Block of Sinclair Lane , Baltimore , MD (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 25, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item.23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD Registrar's Signatur 31. Date filed (Month, Day, Year) State Registrar

09-07032 James Murray

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1-For State Registrar	Cert	ificate of		and mone		_	eg. No.	EU	09 3 3	
Physici	an/	1. Decedent's Name (First, Middle,Last) James Ron	el B	onds		<u> </u>		2. Date of Dea	h	ear	3. Time of Death	
edical Exami	iner	JAMES R.			NDS _			Month Septembe			2043 hrs	
		Facility Name (if not institution, give street and number)     Prince George's Hospital Center		4	Cheverly	, or Location of	Death		4c. County Prince	g of Death George		
Funeral			(In vrs. las	st birthday)	If Under 1		24Hrs.	8. Date of Bir			hplace (State or Foreign	
Director		577-60-8263 1XM 2_F 6		Yrs.		Days Hours	Min.	1	2 1946		IRGINIA	
ku k		Usual Residence of Decedent  10a. State 10b. County 1	Oc. City, 1	Town or Location	on	-					10d. Inside City Limits	
nd how a	_	MD PRINCE GEORGE'S		LANDOV	ER						1 X Yes 2 No	
Maryland 28a-f show any d at once.	Director	10e. Street and Number			10f. Zip Coo	le		1	0g. Citizen of V	What Cour	ntry?	
the N Sa or 2		2408 BRIGHTSEAT ROAD # 1			207	785			USA			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Rygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 X Yes 2	verin U.S Airfo	3. 13. Was	Decedent of s, specify Cu	Hispanic Origi ban, Mexican,	in? ( Spe Puerto f	ecify Yes or No Rican, etc.)		ce - Americ nite, etc.	can Indian, Black,	
fter de		3 Widowed 4 ViDivorced If Yes, Give Yeer	No			No specify:			Specify	/: 'R1	LACK	
ours at atural camin	d by	15. Decedent's Education (Specify only highest grade comp	leted)	16a. Decedent	's Usual Occ	upation (Give k			16b. Kind of E			
6 172 ho	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	-)	during mo	st of working	life. DO NOT t	use retire	ed)	ľ			
within iene.	E G	12TH		LABOR	ER.					VATE		
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	a	17. Father's Name (First, Middle, Last)							Maiden Surnam	1e)		
212 uld be Ments mark	OB	ARTHUR BONDS  19a. Informant's Name/Relationship (Type, Print )		19b. Mailing	Address (S	V I K		A HUTO		own, State	, Zip Code)	
MD and 2 sho alth and 37 is		JEANETTE SMITH/DAUGHTER		1513	JUTEWO	OOD AVE	NUE	LANDO	VER,MAR	YLANI	D 20785	
re, land f. Heal		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State		ace of Disposit		f cemetery,		Date	20c. Location	n - City or	Town, State	
Pages nent o lant: J		4 Donation 5 Other Specify:	٦	ERDALE	CREMAT						,MARYLAND	
Baltimore, permit. Pages I an Department of Hee Important: If ite Imjury or other trans.		21. Signature of Funeral Service Licensee		ľ		ress of Facility					AL HOME D 20785	
Physician		23a. Part I. Enter the disease, ir complications that caused the failure. List only one cause on each line.	ne death. I								Approximate Interval Between Onset and	
/Medical Fxaminer		Immediate Cause (Final disease a Hypertensive Car	rdiovas	cular Diseas	se						Death	
		or condition resulting in death)  Due to (or as a conseq	uence of)	*								
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause										
isi e	Examiner	(Disease or injury that initiated events resulting in death) Last    C.    Due to (or as a conseq	uence of)	:							-	
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760, Icate be physici the buri		IF FEMALE: 23c. If yes, outcome	of pregna	ancy	0,10/1				23d. Date	of delivery	,	
Sox 687 leath certific e attending p for use as th	sician	23b. Was decedent pregnant in the past 12 months?	me of dea	th ====================================	al death	3 Ectopic	pregnar	псу	Month	C	Day Year	
Box 68 c death certif the attending	ysic	1 Yes 2 No 9 Unknown 9 Unknown		5 Oth	er (Specify)							
O. Inat the carbon the carbon to	y Phy	Part II. Other significant conditions contributing to death b	out not res	sulting in the ur	nderlying cau	se given in Par	t I.	23e. Did to	bacco use cor	ntribute to	the cause of death?	
of Vital Records, P.O. ng Physician: The law requires that th ther this certificate has been signed by meral director, page 2 should be detach	ed by							1 Yes	2 No	3 Prob	pably 4 V Unknown	
ords, w requir	Completed							24a. Was autop	sy	prior to c	topsy findings available completion of cause of	
Recc The lar	E							perfo	med? 2 No	death? 1 ✔ Ye	es 2 No	
ital Recician: The scertificate rector, page	Be	25. Was case referred to medical examiner?			26.P	lace of Death (	Check o	nly one)				
Physic arthis	٥	1 ✓ Yes 2 No		ER/Outpatient					Residence 6		:	
<b>-</b> ⊈ . ^ ₽	Certification:	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day,Yea	ur)	28b. Time of In		Injury at Work? Yes 2		28d. Describe	now injury occi	urred		
Division spital or Attendir hours after death.	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injur	ry - At hor	ne, farm, street	, factory, offi	ce building, etc				nber or Ru	ral Route Number, City	
Dj spital nours a neral l	Cert	4 Homicide determined (Specify)						or Town, S	nate)			
To the Hos within 24 h To the Fur completely	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinant manner stated.										
F 3 F 3	ğ.	29b. Signature and title of certifier		_	29c. Lic	ense number			29d. Date sig	gned (Mor	nth, Day, Year)	
		Gill lon	11	$\hat{\mathbf{p}}$	0.	C.M.E.			Septemb	er 9, 20	09	
Φ		30. Name and address of person who completed cause of dea Russell Alexander MD. Assistant Medical	•	•	Penn Stre	et, Baltimo	re. MΓ	21201			·	
St	ate					.,						
Regist	rar	31. Date filed (Month, Day Year) 32. Registrar's	a. 19	parket								

Physici	an	1. Decedent's Name (First, Middle, La	·		Certifica			2. Date of Month	Reg. No Death Da	ay Yea		
/Medic	al	William Carl		•	- Tu -	. ~		Septe		22 20 County of De	09 1:51a [™]	
Examin	er	4a. Facility Name (If not institution, given Carroll Hospice	·		4b. Cr		ocation of De inster	atn		Carroll	eatn	
Funeral Director			Sex 7. Age 7. Age 75	(In yrs. last birt	hday) If Und Month	der 1 Year is Days	If Under 24 H Hours Mi	n. 8. Date of (Month, May 3	Day, Year)	)	Birthplace (State or Foreig Country) MD	
f show	or	Usual Residence of Decedent  10a. State 10b. County Fred	erick	10c. City, Town	or Location Airy						10d. Inside City Limits	
a or 28a- Le refiff	Funeral Director	10e. Street and Number					10f. Zip Code 21771			itizen of What	Country?	
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Ite Madical Examinations to citied at		1117 Oak View Dr  11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 【XDivorced	12. Was Decedent E Armed Forces? 1√2 Yes 2 □ N If Yes, Give Year or Dates:		13. Was Dec If Yes, s		panic Origin? , Mexican, Pue Specify:	(Specify Yes or erto Rican, etc.)		JSA  14. Race - Ar Black, Wi		
		15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5			work done du use retired) sette:	ring most of w	orking 16b. Kind of Business/Industry tiling ame (First, Middle, Maiden Surname)				
Mental Hy arked oth atic event	To Be Completed	17. Father's Name (First, Middle, Last John William						ame (First, Mide Virgin		_		
and 2 sho ealth and I n 27 Is ma er trauma		19a. Informant's Name/Relationship Donna Carroll (da						Rural Route Nui #7,Man				
Department of Hes Important; If item any injury or othe once.		20a. Method of Disposition 1			Disposition (A y, crematory of lence C			Date .5-09		•	or Town, State	
Departrice limborta any inju once.		4 Donation 5 Other (Specify) Providence Cemetery 9-25-09 Kemptown,  21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD 21784										
ysician Medical aminer		23a. Part 1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on , ach lin a.	the death. Do ne.	uot enter the m	ode of dying	, such as card		y arrest,	.1704	Approximate Interval Between Onset and Death	
physician and the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	a consequence o								
by the attending ph tached for use as th	Physician/Med									23d. Date of delivery  Month Day Year		
igned be de	þ	Part II. Other significant conditions	contributing to death bu	it not resulting in	the underlying	g cause giver	in Part I.			use contribute	e to the cause of death?  Probably 4 1 Unknown	
page 2 should	Completed							24a. W au pe 1 □ Ye	itopsy erformed?	prior death	autopsy findings available to completion of cause of ? 'es 2 □No	
certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 █ No	Hospital:	- AC 50'S		Other		eath (Check on	ly one)		12	
tor: After this the funeral di	Certification: To	1  Yes 2 1	28a. Date of Injui (Month, Day	nt 2 ER/Out ry 28b. T r, Year) Ir		28c. Injury Work?	4 ⊔ Nursing at	Home 5 ☐ R 28d. Descrit		6 Other (Survey occurred	ipecity) Devel	
	ü	3 ☐Suicide 6 ☐Could not b	e 28e. Place of Inju	ry - At home, far	m street fact	ory office		28f Location	n /Street a	nd Number or	Dumi Dauta Mumbar	

State Registrar

DHMH 17 Rev 1/2001

09/22/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 29 2009 SEPT 5:50p HAROLD GEORGE BOONE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA 8. Date of Birth (Month, Day, Year)
Oct. 24,1940 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 € M 2 □ F Months Days Hours 218-36-7185 68 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Exprint. In this profit of any or other traumatic event, the Medical Exprint. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11355 Frederick Road 21042 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14∑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 ☑ No If Yes, Give Year or Dates: Specify White Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Repairman Elementary/Secondary (0-12) College (1-4or 5+) Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Boone Grace Lambert ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Linda C. Boone / Wife 11355 Frederick Road, Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 7,2009Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation ServicesPA 1 2nd Ave.SW Glen Burnie, MD 21061 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** heonie /Medical Due to (or as a consequence of Examiner Sequentially list conditions, to you have cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 2 No 3 Probably 4 Unknown Completed 1 🗀 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2)X No 1 ☐ Yes 2X No 1 ☐ Yes 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation ours after death.

eral Director: Al
filled in by the fu 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) MD43 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARIEL LOPEZ-CHAVEZ 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Dav Year Month **Physician** Z:15AM 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Hmore Lrvington If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days 1**№** M 2□ F 15 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Experience is ust be notified at 1 ☐ Yes 2 No Director timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban-Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No , or 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) /rucking is marked other Father's Name (First, Middle, Last) Be Pages 1 and 2 should be innent of Health and Mental 19b. Mailing Address (Street and Number or Byral Route Number, City or Town, State, Zip Code) Informant's Name/Relationship Important: If item 27 is any injury or other trainonce. Baltimore, 20b. Place of Disposition (Name of pemetery, crematory or other, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 Removal from State Department 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service License BaltomoreNations 23a. Part 1. Enter 1 e disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hiert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be execu Due to (or as a consequence of) P.O. Box 68760 Physician/Medical aftending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ★No 24a Was an page 2 autopsy 1 ☐ Yes 2 SINo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Vital Hospital or Attending Physician: Division of within 24 hours after deat To the Funeral Director: J completely State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRENEZEW OVALADO W 33.5 WILLERS AVE #307

32. Registrar's Signatur

00061765

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 0503 AM Bauer, III SEPTEMBER 28 Edward 2009 Fred /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A JOHNS HOKKINS BAYVIEW MEDICAL CENTOR BALTIMOZE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Days Hours Min 1 3 M 2 □ F 56 5,1952 Maryland Nov. Director 217-56-671<u>0</u> Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Modical Examination at the fact 1 ☐ Yes 2XXNo Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21222 United States Funeral 255 Trappe Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married 1 ☐Yes 2 ☐XNo Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates Specify: 2 White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) N/A Disabled 10 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anne C. Foehrkolb 2 Fred E. Bauer, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any injury or other trau 255 Trappe Road Dundalk, Maryland Mrs. Anne C. Bauer (Mother) altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State Sacred Ht. of Jesus Cem. 9/30/2009 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lices Duda-Ruck Funeral Home of Dundalk, Inc. Þ 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HYPOXYS /Medical Due to (or as a consequence of): Examiner ASPIRATION PNEUmeniA Sequentially list conditions, Due to (or as a conse juence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Exam sician and burial-trans Due to (or as a consequence of): Box 68760; attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) □Yes 2□No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier SEPTEMBER 28, 2009 125-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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N. Conceine

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09-07334 Eugene Chambers	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene								1								
	F	- For State Registrar					-	ificate o						Reg. No	40	83	0 4 5 5
Physician Medical Examine	er	1. Decedent's Nam			Eugene			s					2. Date of De Month Septemi	Day per 18,			3. Time of Death 2345 hrs
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any	-	Usual Residence o 10a. State	f Decedent 10b. County				10c. City, T	Town or Loca	ation	-						Τ.	0d. Inside City Limits
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r death w		11. Marital Status  1 X Never Marri			12. Was Dec Armed Fo 1 Yes If Yes, Give Yea	orces? 2			Yes, spec	cify Cubai		n, Puerto F	ecify Yes or N Rican, etc.)	No-	14. Race - A White, e Specify: W	etc.	n Indian, Black,
2 hours after "natural"  "Examine:	핡	15. Decedent's Ed			or Dates:		npleted)	16a. Decede	ent's Usua	al Occupa	tion (Give	kind of we	ork done	16b.	Kind of Busin		
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21215-C 21215-C sould be filed v Mental Hygi marked oth		17. Father's Name			Eugene	L.	Cham					Lou		. Cha	ambers		
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altimore, mit. Pages I an partment of Heal portant: If iten lury or other tra		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Cedar Hill Cemetery  09/22/2009  Baltimor							-								
Baltimo permit. Page Department Important: injury or ott	1	21. Sign of u			Drid	a	ر ج								Servi re, Ma		P.A. and 21225
Physician // // // // // // // // // // // // //	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and					
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Division of Vital   To the Hospital or Attending Physician: within 24 hours and electric acts. To the Funeral Director: After this certificant completely filled in by the funeral director. Medical Certification: To Be (		29a. Certifier 1		miner:	n: To the bes On the basis of	of exar	_										
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8		OU AH	ess of person		un w		eath /Itom 3	(3a)		O.C.	M.E.			Sep	otember 1	9, 20	09 
		Melissa Bra	ssell, MD		sistant Me				Penn S	Street, E	Baltimor	e, MD 2	1201				
State Registra		31. Date filed (Mont		200		egistra	r's Signatur	do	AL P								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}25, Physician/ September Da 2009 12:28 AMM Theresa Elizabeth Crist Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min Director 79 Nov Maryland 220-24-9686 Usual Residence of Decedent 28a-f show is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d, Inside City Limits Director 1 Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral a.m. 4401 Arabia Avenue 21214 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Yes 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation unk 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) daycare 8 0 Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental ပ permit. Page 1 and 2 should be Department of Health and Ment Elmer Jacob Wineke Phyllis Mary Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SEPTEMBER Department of Health a Important: If item 27 is any injury or other trae Victoria Crist/daughter 2511 Wendover Road Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 X Donation 5 Other Specify) Signatur of Tral S RONA I 22. Name and Address of Facility S. Wade Board 655 W. Baltimore Street Baltimore. 21201 MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ LIVER CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Cause (Disease or linjury that initiated events that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Year 1 ☐ Yes ∠ 29 ☐ Unknown page 2 should be detached been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 24 hours after death. 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has perform 1 Yes 2 No Yes 2 X No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2X No Other မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural iniury 5 Pending 1 Yes 2 No Accident Investigation ☐ Acciden☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760 THERESA CRIST within 24 hours after deat To the Funeral Director:

> State Registrar

4 Homicide

29a Certifier

(Check

29b. Signature and

**JACKIE** 

Medical

determined

JONES, CRNP

Certifying Nurse Practioners to the best of my knowledge

of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

coursed at the time, data and place, and due to the

28f. Location (Street and Number or Rural Route Number,

29d, Date signed (Month, Day, Year)

200°

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 25 2009 Physician 9:15 ам Teddie Lee Cline /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Min. Hours 1 □XM 2 □ F Days 76 233-48-8641 Director 22,1933 West Virginia February Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show Injury or other traumatic event, it is Medical Examiner must be righted at Director 1 ☐ Yes 2 No Anne Arundel Pasadena MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 1163 Ridge Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1 ☑Yes 2 ☐ No Black, White, etc 1 ☐ Never Married 2 🔀 Married Yes 2 Yes Give 1 ☐ Yes 2 TNo Specify Specify: White þ Year or Dates 1962-65 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sergeant First Class U.S. Army permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dula Cline Violia Hatfield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Cline wife 1163 Ridge Drive Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/28/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Bavview Crematory 22. Name and Address of Facility McCully Polyniak Funeral Home PA 21. Signature of Funeral Service License any ONATO 3204 Mountain Rd. Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** aspiration disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Ye ar 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 2 @No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 □Yes 2 🗆 No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) within 2 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D58510 address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Records,

Division of Vital

Olexa

32. Registrar's Signature

-e

31. Date filed (Month

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Ma	ryiana / Depa <i>Ce</i>	artment of F rtificate of I		-	ene g. No.	9 9 11.42
	Dh		1. Decedent's Name (First, Middle, La	ast)				Date of Death     Month	Day Yea	3. Time of Death
	Physici /Media		Willie Deloatc	h				Septemb	er 20, 20	009 8:50 PM M
	Examir	er	4a. Facility Name (If not institution, gi	·			Location of Death		4c. County of De	
and the			Anne Arundel Me 5. Social Security Number 6.			Annapol:	is If Under 24 Hrs.	O Date of Dieth	Anne Ar	
	Funeral Director			1 M 2 □ F	(In yrs. last birthday) 69 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct 7, 1	939	Birthplace (State or Foreign Country) unk
	land ow		10a. State 10b. County		10c. City, Town or Lo	cation		-		10d. Inside City Limits
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	h the	ji e	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	23a c	Funeral Director	900 Van Buren S	treet			21401		USA	
	tems	nue	11. Marital Status unk	Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A	merican Indian, hite, etc.
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Mydical Exprainter russt be notified at	ρ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1	° unk	1 □Yes 2XINo	Specify:		Specify: b	lack
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lary	2 shou and N is ma auma		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Street	and Number or Rura	al Route Number,	City or Town, State	e, Zip Code)
	and realth m 27		Anne Arundel Med	lical Center	·		Pkwy Anna			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en Once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	w in state	20b. Place of Dispo cemetery, crer	sition (Name of natory or other plac	e)	Date 20	Oc. Location - City	or Town, State
Balt	permit. Depart Import any inj		21. Signature of Funeral Jervice Lice	Wade Dire	ctor St		ss of Facility omy Board MD 2120		Baltimore	Street
			23a. Party. Enter the disease, or com shock or heart failure. List only	nplications that caused to	the death. Do not ent				st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Phe	CIM BALL	X				Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
Ö,	rificate be executed ng physician and as the burial-transit		that initiated events resulting in death) Last	c Due to (or as a	consequence of):					
68760,	cate b ohysic the bu	edical		<b>d</b>						
			IF FEMALE:	23c. If yes, outcome of	of pregnancy					
O. Box	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after feath.  Within 24 hours after feath.  Within 24 hours after feath.  Completely filled in by the funeral director, page 2 should be detached for use a completely filled in by the funeral director.	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	у		Month	delivery Day Year
ر. ح.	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant conditions	contributing to death but	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
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Division of	ding Physician: The Ih. h. After this certificate he funeral director, page	.i.o	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day,	Year) 28b. Time of Injury	Work		28d. Describe how	injury occurred	
Sic	Attend death ctor: / y the f	icati	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 290 Place of Injur	ry - At home, farm, stre		Yes 2 □No	201 1	-4 d M 6	0. (0
<u>&gt;</u>	al or Attend s after death il Director: ed in by the f	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	set, factory, office		City or Town,		Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifler (Check only one) 2  Medical Example	hysician: To the best of miner: On the basis of and manner state	examination and/or in	n occurred at the tir vestigation, in my o	me, date and place, pinion, death occurr	and due to the car ed at the time, dat	use(s) and manner te and place, and c	r as stated. due to the cause(s)
	To th within To the comp	Me	29b. Signature and title of certifier	4		29c. License	e number	290	d. Date signed (Mo	onth, Day, Year)
		-	30. Name and address of person who	completed cause of de	ath (Item 23a) (Type,	Print)	7 1	1 1	1/20	/9
			Acrec	Yn	<u>+</u>	nne P	tradel	Med	(00)	67 62
	Sta Registra		31. Date filed (Month, Day, Year)  OCT 0 1 20	32/Registrar	's Signature	Kel				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** DORSEY HERMAN SEPTEMBER 25 2009 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examine Apt. 402 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 M 2 D F Months Hours Min 6 9 Yrs 219-26-6115 Director 7.1940 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show the Medical Examiner must be notified at 1 Res 2 No Funeral Director nmore 10e. Street and Number 10g. Citizen of What Country? ISA . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in Armed Forces? 11. Marital Status 14 Bace - American Indian filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 o. 1 ☐ Yes ➤ No Specify ģ 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Many once. Elementary/Secondary (0-12) College (1-4or 5+) me. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be erman 0255 ဥ ease 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number (Daughter) Alameda Hinore, ND 21219

20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific 3 Removal from State 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosaleration Cardiovascular **Physician** Years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of) attending physician Records, P.O. Box 68760 Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) the page 2 should be detached 9 D Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an has autopsy performed? After this certificate of Vital 1 □ Yes 2 🔀 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I the

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

HENDOZA TAGLE HD.

0 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301 Sant Paul Place

32. Registrar's signatu

29c. License number

D535

Baltimore, Maryland

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death **Physician** 2009 Esther Marv Doll-Deal /Medical 4c. County of Death Examiner 5. Social Security Number If Und last birthday Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 2□F 219-03-6735 Yrs Director 92 13. 1917 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director Marvland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? #1 Summit Hill Ct. Apt. B-4 21228 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify:White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Department Store permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important; If item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be William C.F. Long Catherine May Duffy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #1 Summit Hill Ct., Apt.B-4, Catonsville, MD 21228 Gail C. Dawson (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemeter'v 9/29/09 Woodlawn, MaRYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy
Live birth 2 
Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 2 No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide cal 29a, Certifier 🛙 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Hospital or Attending Physician: The Division of Vital within 24 hours a

To the Funeral D

Records,

Maryland 21215-0036

Baltimore,

State Registrar

(Check only one) 29b. Signat

31. Date filed (Month, Day,

nd title of certifie

Year

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

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				epartment of Health an Certificate of Death	n Mental Hyglene Reg. No.	100 31109							
f	Physici		1. Decedent's Name (First, Middle, Last)  John William I	Oodge, Jr.	2. Date of Death Month Day	Year 7:10 A M							
H.	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De		009   " To To Williams							
- Andrew	Funeral Director		$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	Months Days Hours M		timore  9. Birthplace (State or Foreign Country)  Maryland							
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	or 28a	Director	Maryland Baltimore 10e. Street and Number	Nottingh 10f. Zip Code		f What Country?							
	ath wil		4139 India Avenue	21236		d States							
21215-0036	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show he he deat Eventine routh be invitted at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 □ No  If Yes, Give  Ye ar or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt 1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No- lerto Rican, etc.)  14. Ra Bla	ace - American Indian, ack, White, etc. ify: White							
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/lar	2 should be to and Mental is marked or aumatic eve	To B	John W. Dodge, Sr.	Rut	h Byroad								
, Maryland	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If item 27 is marked any injury or other traumatic e once.			Mailing Address (Street and Number of 139 India Ave. N	Rural Route Number, City or Town ottingham, Mary]								
Baltimore,	Pages 1 nent of Hi ant: If iten ary or oth	531		isposition (Name of crematory or other place) Hill Mem. Gdns. 9/		- City or Town, State Le River, MD							
Balt	permit. Departi Importa any inje		21. Sign sure of rugitral Service Licensee	22. Name and Address of Facility Duda-Ruck Funeral 7922 Wise Ave. D	Home of Dundall	inc.							
F			23a. Part f. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as care	diac or respiratory arrest,	Approximate Interval Between							
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ita		Be C	25. Was case referred to medical	26. Place of C	1 ☐ Yes 2 ☑ No Death (Check only one)	1 ☐ Yes 2, ☑ No							
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isic	or Attending after death. Director: Afte In by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm	M 1 □Yes 2 □No	28f. Location (Street and Num	ther or Rural Route Number							
<u>S</u>	tal or / s after al Dire ed in b	Certification: To	4 ☐ Homicide determined building, etc. (Specify)	,,,	City or Town, State)	bor or mural modile ryumber,							
	In the Hospital or All within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  1 ★ Certifying Physician: To the best of my knowledge, c 2 ★ Medical Examiner: On the basis of examination and/c and manner stated.	leath occurred at the time, date and pl or investigation, in my opinion, death o	ace, and due to the cause(s) and n ccurred at the time, date and place	nanner as stated. , and due to the cause(s)							
1	To the within 2 To the comple	Ž	29b. Signature and jubble certifier	29c. License number	29d, Date signe	ed (Month, Day, Year)							
		-	- JY MIN JOURNAL	H-00634	76 09/2	8/2009							
			30. Name and address of person who completed cause of death (Item 23a) (Ty David Madder D. 0./492	pe, Print) 1 Campbell Bl	vd. #200 Ba	HO.MD 2636							
	Stat Registra	_	31. Date filed (Month, Day, Year) \$2. Registrar's Signature	pe, Print) H Campbell Bl									

Amend #5 & 11, per FH G896 10/21/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4:40 PM CHARLES Ε. DONHAM 28 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral**  Date of Birth (Month, Day, Year) 1 M 2 □ F Months Days Hours 219-70-5565 5464 48 **Director** June _ 17,1961 Maryland 1 4 1 Usual Residence of Decedent the Maryland 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Markal Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 2 X No Director Anne Arundel Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5318 Wasena Avenue 21225 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Donham Roxie Myers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxie Ege (Mother) 5318 Wasena Avenue, Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Bayyiew Crematory 09-29-09 Baltimore, Maryland 4 Donation 5 DOther (Specify) 22. Name and Address of Facility 21. Signature of Furderal Service License MCully-Polyniak Funeral Home P.A. 1237 Fast Patapsco Avenue, Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician Sepsis MRSA disease or condition resulting in death) week /Medical Due to (or as a consequence of): Examiner Endo cardetes Severe Mitral Regunstration and 3 month with Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Vegetation sician and burial-transit Physician: The law requires that the death certificate be executed Sepha Emboli Due to (or as a consequence of): P.O. Box 68760, aftending physician Physician/Medical Diabetis mellitus as the use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe certificate 2 No 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending Pon 24 hours after death.

The Funeral Director: After the Funeral Director of the funeral pletely filled in by the funeral post of the funeral post of the funeral of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral post of the funeral po 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐Yes 2 ☐ No 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ansor 9 28 2009 M.D AT-2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar MOZAYAN

31. Date filed (Month, Day, Year)

Hospital.

Baltimore.

MD 21218

Unon Memorial

/32. Registrar's Signature

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name of address of person who completed cause of death (Item 23a) (Type, Print)

GENEN

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 3. Time of Death Physician/ Candice Fullwood 2°4 2009 10:30aM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Balto Catonsville 329 Lane Apt 801 Winters If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F 2 - 1 - 1 9 Months Days Hours Director N.C. 34-8239 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Catonsville 1 ☐ Yes 2 🛛 No MD Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 Winters Lane Apt S A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Black 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done (life. DO NOT use retired) should be filed within 72 hand Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Home 8th grade Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irene Jones David Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a JoAnna Brown-Niece 1918 W. Lafayette Avenue Balto, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If if any injury or or 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 10-2-2009 Arbutus, March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wa MD 21202 Balto, 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, it any, leading to incrediate cause. Enter Underlying Examine that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of): attending physician Physician/Medical 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires within 24 hours after death.

Within 24 hours after death.

Or the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ပ္ 1 Tes Residence 6 - Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 
Yes 28d Describe how injury occurred Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29d. Date signe Name and address of person who completed cause of death (Item 23a) (Type,

State Registrar Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#195 perFH, G896, 10/7/09, WS, #7

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 09 Physician/ 2009 Purcell Maurice Gray 9:25a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Catonsville Manor Care Nursing Home 8. Date of Birth (Month, Day, Year) 12 25 Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 1 XM 2 □ F 91-90 Yrs **Director** 216-07-2265 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1X Yes 2 □ No Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò "natural", or items 23a o Funeral U.S.A. 21215 3216 Burleith Ave hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 No Maryland 21215-0036 Black 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Iant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the Postal Worker Mail Clerk 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Viola Ford Youngie Gray 19b. Mailing Address (Street and Number of Burle Number, City or Town, State, Zip Code)
3216 Burleith <del>Road</del>, Baltimore, Md 21215 19a. Informant's Name/Relationship (Type, Print) Elaine Gray-Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet 10/2/09 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final TEOMYEUITIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** EUMONI Sequentially list conditions, Examine day, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury Day to for as a consequence of attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death signed by the a 2 🗌 No q Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wunknown icate has been sig ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) a safter dea... 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be within 24 hours arranged to the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of gramination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: Jothe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 10061765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLICENS ANE #307 BALTIMORE MO 21229 (DUAINOO WD 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Robert J. Groves Sept. 5:52p 28 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery County General Hospital 01ney Montgomery 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 1 M 2 □ F 235-20-8256 Director May 21 1922 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Madical Examiner must be notified at MD Howard Woodbine Director 1 ☐ Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 3273 Jones Road 21797 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. WWII 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 2 Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) education math teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If Item 27 Is marked o Harvey Clyde Groves Elsie J. Harned 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Henderson (daughter) 55 Yingling Rd., Gettysburg, PA 17325 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Pipe Creek Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10-4-09 New Windsor, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Page Squader Sterbert | P.O. Box 195 Sykesville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 195 Sykesville, MD 21784 Physician 5 Due to (or as a consequence of): disease or condition resulting in death) /Medicai Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initialed events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No Division of Vital 1 □ Yes 1 ☐ Yes 2 ∏ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1☐Inpatient 2☐ER/Outpatient 3☐DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one)

State Registrar 3416

30. Name and address of person who completed cause of death (1em 23a) (Type, Print)

Print) Seytember 28,2009

Print) 2085 2

Olandward G Dlary Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8:00 A^M William Frederick Greives 25 2009 Sept. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dunda1k Baltimore 841 Mildred Avenue If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min Country 1 XM 2 ☐ F Maryland 220-24-4508 Director 80 1929 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov 1 ☐ Yes 2 No Dundalk Director Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 841 Mildred Avenue 21222 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2 🙀 No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: if item 27 is marked other thi any injury or other traumatic event, the once. Construction 8 Years <u>Bricklayer</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Francis Greives, Sr. Catherine Margaret Wendelstedt ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 Dundalk, Maryland Mrs. Mary K. Greives (Wife) 841 Mildred Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. Of Jesus Cem. 9/29/2009 Dundalk, MD 5 Other (Specify) 4 Dopation 21. Signature of uneral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Int 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCLEROTIL DISTAGE **Physician** (ARDIOVASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospitat or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 □Yes 2 □ No. 9 🗆 Unknown s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has trirector, page 2 s autopsy perform 2 No 1 ☐ Yes 2. No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 ☐ Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760, within 24 hours a

> State Registrar

> > DHMH 17 Rev 1/2001

29a. Certifie

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Medical

and manner stated.

32. Registrar's S

9106-

ne and address of person who completed cause of death (Item 23a) (Type, Print) m

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

+LADELPHA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Thomas John Glanville, JR. Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day Y September 20, 2009 1535 hrs Medical Examine THOMAS JOHN GLANVILLE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Pasadena 219 Mountain Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday) Social Security Number 6 Sex **Funeral** Country)
Mary Land Months Davs Hours 28, 1981 216-98-0852 27 Oct. Director 1 V M 2 Usual Residence of Decedent 10d. Inside City Limits I0c. City, Town or Location 10b County 10a State Yes 2 No Maryland Anne Arundel Pasadena or items 23a or 28a-f show must be notified at once. after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 219 Mountain Road 21122 U.S.A. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married White Yes Specify Yes 2 / No specify: Yes, Give Year Divorced narked other than "natural", event, the Medical Examiner Widowed 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene. 12 0 None None 18.Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Thomas John Glanville Sr. Carol Baldwin marked æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is m Thomas John Glanville Sr. (Father) 219 Mountain Road, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition 3altimore, crematory or other place)
Bayview Crematory Department of H Important: If i Burial 2 V Cremation 3 Removal from State 09-26-09 Baltimore, Maryland Donation 5 Other Specify: 22 Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Fundral Service Licer 3204 Mountain Road, Pasadena, Maryland 21122 Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** ailure. List only one cause on each line Death /Medical Complications of morbid obesity aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate eause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and <u>ca</u> 23a,27,per ME g896 10/22/09 TT AMENDED X UNPENDED ysician burial -Physician/Medi Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy phy the Year 23b. Was decedent pregnant in the Month Day attending por use as the Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ð Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy s certificate has b rector, page 2 sh performed? death? 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical **Civision of Vital** Be examiner? Nursing Home 5 Residence 6 ✔ Other: Scene 1 V Yes No

this certifi Hospit or Attending Physician; After within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

Certification:

g

2

4

Other 4 Hospital: 1 ER/Outpatient 3 Inpatient 28c. Injury at Work? 28b. Time of Injury

28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 1 Yes 2 No Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc.

29d. Date signed (Month, Day, Year)

September 21, 2009

Could not be or Town, State) Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number Signature and title of certifier O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)

Pending

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD.

and manner stated

31. Date filed (Month, Day, Year) State Registrar

27. Manner of Death

Accident

1 X Natural

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** September 19, 2009 4:00 AMM Florence Holden /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Roland Park Place Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, May 27, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** Months 1 □ M 2 😿 F 99 Wisconsin 215-40-0672 Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1√EYes 2 No Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21211 830 W. 40th Street Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🙀 No altimore, Maryland 21215-0036 Specify. Specify: white ş 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Enoch Pratt Library private secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Morgenroth Edwin Chapin Holden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trauonce. Ann Bresee/neice 4 Kitzbuhel Road Parkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2 ☐ Cremation 3 Removal from State 4 Donation 5 D Other (Specify) 21. Signal re of Euroral Service Licenser Ronald S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street irector Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) endstage Due to (or as a consequence of): dement 14 hysician Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2☐ No 24a. Was an autopsy performed certificate 1 25. Was case referred to medical examiner? funeral director. 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Medical Certification: To 24 hours after death. Funeral Director: After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide

State Registrar

DHMH 17 Rev 1/2001

completely

within 24 the

2

31. Date filed (Month, Day,

29a. Certifier

(Check only

29b. Signature and title of certifier

3. Registrar's Signature

5901

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

M.D.

north

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

CHAPLES Street Balfimore Maryland

cian		1. Decedent's Name (First, Middle, La					2. Date of Dea Month	Day	Year	3. Time of Death
ical			ERNADE				Septemb		<b>6</b> , <b>2009</b> unty of Death	9:35 PM
iner	4	la. Facility Name ( <i>If not institution, gi</i> HAR bor	HosbitA	(		, or Location of Deatl altimore	1		/A	
Ī	5	5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birtho	fay) If Under 1 Yea	ar If Under 24 Hrs.	8. Date of Birth			ace (State or Foreign try) y land
r		219 12 9379	1□ M 2 <b>X</b> F	85 Yrs	Months Day	ys Hours Min.	02/22	/1924	Mar	yland
	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location				10	d. Inside City Limits
į		Maryland N/A		Balt	imore					1 XYes 2 No
ı.	1	10e. Street and Number			10f. Zip Cod	e		10g. Citizer	n of What Count	try?
2	3	3809 St. Marga	aret Street			21225		U	.S.A.	
Funeral Director	1	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	<ol> <li>Was Decedent of If Yes, specify C</li> </ol>	of Hispanic Origin? (S uban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14.	Race - America Black, White, e	
P > E	5	1 Never Married 2 Married 3 Married 4 Divorced	1 □Yes 2 ☑ If Yes, Give Year or Dates:	No	1 □ Yes 2 🔼 N	No Specify:		Sp	pecify: Wh	ite
Pot	3	15. Decedent's E	Education	16a. D	ecedent's Usual Oc	cupation	dein a	16b. Kind	of Business/Ind	ustry
Completed	-	(Specify only highest gi	College (1-4or 5	)+) I		ne during most of wor ired)	Kiriy		Own Ho	m.o.
5	3 -	12th	-1)	1	Homemaker	10 Mothor's Nor	ne (First, Middle,	Maidan Su		
a a	š	17. Father's Name (First, Middle, Las	Albert R.	Schumach	ner		ace C.,			
٢		19a. Informant's Name/Relationship	(Type. Print)	19b. N	lailing Address (Stre	eet and Number or Ri	ıral Route Numbe	er, City or To	own, State, Zip	Code)
		Susan Household	der / Daugh	iter 38	09 St. Ma	rgaret St	reet Bal	ltimo	re, Mary	yland 2122
	2	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [	□ Romaval from State	20b. Place of D cemetery,	isposition (Name of crematory or other p		Date		tion - City or To	
		4 □ Donation 5 □ Other (Spec		Cedar H	[i11 Cemet	CLY	30/2009			Maryland
ļ		21. Signature of Funeral Service Lice	ensee		22. Name and Ad	•	once Fund			, P.A. land 21225
	+	Jerome gr	concoc	1 6 84 4						101111 Z 1 Z Z J
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(Specify)  of my knowledge, of examination and/ated.	atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  atient 3 DOA  at	ancy  given in Part I.  26. Place of De. Other: 4 \( \text{Nursing Injury at Vork?} \) \( \text{Yes} \( 2 \text{ No ce} \)  the time, date and place in yopinion, death occeense number	23e. Did to 1	23c  Display rest,  23c  23c  23c  25c  25c  25c  25c  25c	d. Date of deliver Month  contribute to the No 3 Proberto condeath? 1 Yes  Other (Specify accurred)  Number or Rural accurred accurred accurred accurred.	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State Registrar 31. Date filed (Month, Day, Year) OCT 0 1 2009

DHMH 17 Rev 1/2001

MD 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 0503 **Physician** M ORetta september 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deal Examiner Byriew Medical Con HOPKINS Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Min. 1 ☐ M 2 🛛 F Months Davs Hours Mary Land 219 26 5267 68 02/01/1941 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Machical Examiner mast by mathed at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 □Yes 2X No Director Dunda1k Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 U.S.A. 1620 Four Georges Court Apt. A4 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: Completed by White 3 Widowed 4 Divorced 16b. Kind of Business/Industry Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fred Bachman Jr. Anna Leech ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1620 Four Georges Court Apt. A4 Dundalk, MD. 21222 Norman Harvel / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or Marriottsville, MD. Crestlawn Cemetery 09/25/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway nomerous 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Kespiratory 2 hours disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading of the late cause. Enter Underlying Cause (Disease or injury that initiated events Examiner law requires that the death certificate be executed and use as the burial-trai resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) the 9 Unknown ģ cate has been signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy he perform death? 1 ☐ Yes 2 1 □Yes 2 🗌 No or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No ì Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 2 Accident the after death 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral L Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier les-00

State Registrar Nicole

Avenue, Baltimore Mp 21224

who completed cause of death (Item 23a) (Type, Print)

4940 Easter 2. Registrar's Significan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 30 2009 12:05 AM Jerome Lee Harrington Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death The Woods of Sun Valley Carrol1 <u>Westminster</u> 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Country Minnesota Hours September 21.1935 Director 472-32-2228 74 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b, County ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Maryland 1 🗆 Yes 2 No Carrol 1 Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Pipe Creek Road 21791 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 🙀 Married Completed by 1 X Yes 2 🗆 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White "natural" 3 Widowed 4 Divorced WIT Year or Dates. of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Finance: Chief Financial Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Harrington Leona A. Daugherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William R. Harrington/ Nephew 2 Pipe Creek Road, Union Bridge, Maryland 21791 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 10 /- 69 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Signature of Funeral Service Licensee Anarda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate Yes 2 To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\bowtie$  Other (Specify) ASSISTED LINE 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 Pending iniury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completed filled Medical 29a Certifie 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0014317 September 3D, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ODE KING DRIVE, TAPEYTOWP, MD 21787 LIPTHICOM, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MORE ACTIMOR 60 ANDAUS TOWN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Months Davs Hours 171-12-3206 VIRGINIA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State in then "naturel", or Itams 23a or 28e-f show the Wedical Examiner must be notified at 1 Yes 2 □ No BALTIMORE Director MARYAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 U.S.A. erine Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Itimore, Maryland 21215-0036 Specify: BLACK Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) marked other then Elementary/Secondary (0-12) College (1-4or 5+) Steel RIGGER 18. Mother's Name (First, Middle, Maiden Sumame) permit Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any in ury or other treumatic event. 17. Father's Name (First, Middle, Last) BASHAM VENIA ERNEST 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) , BALTIMORE, md 21223 HARMON WIFE 214 VICLA MARY 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 10 101/2009 4 □Donation 5 □ Other (Specify) Metro CREMATORY 22. Name and Address of Facility The DERRICK C. Jones FIH Signature of Funeral Service Licens 4611 PK Hats. AVE, BALTO. Md. 21215 23a. Part1. Enter the disease, or complications limit caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Vascular Physician erebral ea disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Mellitis 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an

funeral within 24 hours after death.

To the Funerel Director: After completely filled in by the funer.

Be

Certification: To

Medical

State Registrar

pitel or Attending Physicien:

1 Yes 2 No

25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 ☑ No 27. Manner of Death 1 Natural

2 🗌 Accident

3 🗌 Suicide

29a Certifier

4 \( \text{Homicide} \)

5 Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

28d. Describe how injury occurred 1 Tes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number R08419, 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9109 LIBERTY RO RANDALLSTOWN MO WHITEFORD

THA. 31. Date filed (Month, Day, Year)

OCT 0 1 2009

32. Degistrar's Signature

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** 23:13 M 26 2009 sandra Nano estember /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hospital 7. Age (In yrs. la Howard County 1 Year If Un If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🕱 F Months 145-32-7938 Nov. 13, 1943 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8300 Catherine Avenue 21122 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 □Yes 2X No Specify: <u>۾</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Peters Edna Hillery ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darryl M. Jones (Son) 8300 Catherine Ave., Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 10/2/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityLoudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 👿 No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 XNo 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 No investigation

**Examiner** Box 68760, P.0. Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar physician s the burial attending p for use as t signed I certificate has been s rector, page 2 should director, After this funeral of n 24 hours after death.

Ne Funeral Director: A

pletely filled in by the fu death. completely

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Walcal Ever item reust be notified at

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

State

DHMH 17 Rev 1/2001

o

Medical

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

fourted 32. Registrar's Signature

6 Could not be determined

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

apport Medical Docter

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of Ma	aryland	/ Depa	rtment of	Health	and M	lental Hy	giene			
			State Registrar			Cer	tificate o	f Death	7		Reg. No.	2009	91	1,23
	Dhysisi		1. Decedent's Name (First, Middle, L	ast)						Date of Dea     Month	ath Day	Year	3. Time	of Death
	Physici /Medic		JACK	5.	HIG	LEY				SEPTEM	BER I	9 2009	1418	<b>В</b> М
	Examin	er	4a. Facility Name (If not institution, ga				4b. City, Town,				4c.	County of Death		
-1			JOHNS HOPKINS B		e (In yrs. las		If Under 1 Yea	IMOR	er 24 Hrs.	8 Date of Birt	h	N/A	olace (State	or Foreign
	Funeral Director			1 <b>½</b> M 2 □ F	61	Yrs.	Months Day		Min.	8. Date of Birt (Month, Day		Cou	ntry)	
	D		Usual Residence of Decedent		OT					Feb. 7,	1940	S I Ma	ryland	
	rylan show	L	10a. State 10b. County		10c. City, 7	Town or Loc	ation						Od. Inside (	,
	Ba-f s	Director	Maryland N/	'A				imore	City					s 2 No
	vith th		10e. Street and Number				10f. Zip Code				10g. Citi	zen of What Cou	ntry?	
	s 23	Funeral	6132 Bessemer Av	12. Was Decedent	From in U.C.	12.14	ina Dependent of	212		soifu Vaa or No		nited St 14. Race - Ameri		
	ter de	Fun	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?		lf. V	Yes, specify Cu	iban, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)		Black, White,		
21215-0036	urs af	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1	∐Yes 2 🔀 N	o Specif	y:			Specify:	White	2
2	72 hou	Completed	15. Decedent's E (Specify only highest g	Education	1	16a. Deced	ent's Usual Occ	upation	et of work	ina	16b. Ki	nd of Business/Ir		
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. D	kind of work don O NOT use reti	red)	JSI OI WOIKI	ng				
21	ed will her the	ဝိ	unk			Dis	abled_			(F: 4 44: 1 1)		N/A		
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Ĕ	should be filed within 72 hours after death with the Maryland and Mental Hygiene. It marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Evan into internal be notified at	မှ	Jack S. Higley  19a. Informant's Name/Relationship			10h Mailin	a Addraga (Ctra	at and Num		ma Ann		ers r Town, State, Zi	a Cadal	
<u>B</u>	id 2 s lth an 27 Is trau		Susan Higley (Da		- 11		tervale			on, Mar				
ō,	f Hea		20a. Method of Disposition		20b. Plac		ition (Name of atory or other p			Date		cation - City or To	wn, State	
Ë	Page: nent o nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Spec						Cem.	9/30/20	009	Owings	Mills	, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Mcdical Exacting out to ust be notified at once.		21. Signo Lire of Geral Service Lice	- 2	//	22.	Name and Add	ress of Fac	ility					
ñ	Per II D		1 Pal It	prel	if	Ī	Ouda-Ruc 7922 Wis	k Fun	eral	Home of	Dui	ndalk, I yland 21	nc 223	
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	the death.	Do not ente	r the mode of d	ying, such a	as cardiac	or respiratory ar	rest,		Approxima Interval Be	ate etween
¥.	Physician		Immediate Cause (Final disease or condition				AILURI						S MIN	Death
	/Medical Examiner		resulting in death)	Due to (or as		,								
	Lxammer	er	Sequentially list conditions,	b. Due to (or as			SEPSI	٠\$					404	475
1	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 to (or us	a consuper	ice ory:								
1	execuna and ial-tra	Examin	that initiated events resulting in death) Last	c Due to (or as	a consequen	ice of):								
8/60;	ficate be executed physician and s the burial-transit	dical		<b>.</b> d.										
0	tifical ng phy as th										- 1			
X Q Q	death certif e attending d for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregna	ncv				23d. Date of deliv		
	e dea the at ned fo	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)					Month	Day	Year
7.	d by letach	Phy	9 ☐ Unknown  Part II. Other significant conditions	contributing to dooth b	ut not recultiv	a in the un	dadriaa aarraa	ivon in Doe		220 Did to	abacco u	se contribute to	ho cause of	doath?
ecords,	w requires that the death certifice been signed by the attending should be detached for use as	þ	BRAIN DEAT		at not resulti	ig in the dir	denying cause (	jiven iin an	. 1.		es 2		bably 4	
ö	require should	Completed								·				
ĕ	The law ate has b page 2 st	d d								24a. Was autop		24b. Were auto prior to co death?	psy finding impletion of	cause of
VItal	ificate	ပိ	25. Was case referred to medical	1				20 0		1 ☐ Yes	2 ☑No	1 □Yes	2 □ No	
	ding Physician: The law h. After this certificate has funeral director, page 2 s	∞	examiner?	Hospital:	ent 2 🗆 ER	!/Qutnatient	3 🗆 🖸	thor:		n (Check only o		6 □Other (Speci	6.1	
0	g Ph	n:T	27. Manner of Death	28a. Date of Inju	iry 28	b. Time of	28c. In			28d. Describe h			19)	
<u></u>	Attending r death. ector: After by the funer	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	on	y, rear)	Injury		□Yes 2	□No					
DIVISION	r Atte	Certification: To	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		ury - At home c. (Specify)	e, farm, stre	et, factory, office	9		28f. Location (S	Street an vn. State	d Number or Rur )	al Route Nu	mber,
	ital o Ins aft ral Di lled ir			N .										
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o	of examination	edge, death n and/or inv	occurred at the estigation, in m	time, date opinion, de	and place, eath occur	and due to the red at the time,	cause(s date and	) and manner as I place, and due t	stated. o the cause	(s)
	ithin (ithin 2)	Mec	29b. Signature and title of certiller	and manner sta	ated.		29c. Lice	nse number			29d. Dat	te signed (Month,	Day. Year)	
	F≥Fŏ		1. il					5-00				TEMBER		009
			30. Name and address of person who	completed cause of c	leath (Item 2)	3a) (Type F		- 00		4			, , , ,	301
			GRACE THAN	MASUVIM	OL, M	D	4940 E	ASTE	ERN .	AVENU	E, F	BALTIM	DREP	1D 21224
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	Lan	1				. (		_	
	Registra	ar	OCT OT SINK	1 Lenge	pl. y	Charles and								

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Day Year **Physician** JOHNSON 12 20 AM 30 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR BALTIMORE HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours **№**□ M 2□ F 50 212-76-2582 Director 07 28 59 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1√2Yes 2□No Funeral Director Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Int; If item 27 is marked other than "natural", or items 23a or Iry or other traumatic event, the Medical Examinating to a 21229 Brisbane Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: <u>ک</u> Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Edgewood 12th grade Service Technician Management Company 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Pearlyne Hawkins Ralph Ringer Johnson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 541 Brisbane Road, Baltimore, Md 21229 Department of Health Important; If item 27 any injury or other troope. Paula Johnson-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion 10/3/09 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hepatocelular **Physician** 3 week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner cinston Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: The law requires that the death certificate be executed hom Hepatitis C in and burial-trar Due to (br as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) ned by the detached 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 ☑No 24a. Was an has autopsy performed? certificate Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDRES-001 30 2009

State Registrar

# South 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

Harove

Baltimose,

09-07542 Carrie John

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physician	1/	1. Decedent's Name (First, Middle,Las					2. Date of Death Month September	Day Year	3. Time of Death 1847 hrs
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		University Hospital	e strock and namber,		Baltimore				
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. Ia	st birthday)	If Under 1 Yea			(MM/DD/YYYY) 9	. Birthplace (State or Foreign Country)
Director		241-51-6355	м 2X г 29	Yrs.	Months Day	s Hours Mi	01 17	7 80	NC
Α.		Usual Residence of Decedent 10a. State 10b. County	Idoa City	Town or Locati	on.				10d. Inside City Limits
ow any		MD NA	, ,	Balti					1 Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number		Darer	10f. Zip Code		100	. Citizen of What	Country?
the Mg	=	648 Dover Str	eet		2	1230		U.S	.A.
hours after death with the Maryland natural", or items 23a or 28a-f sho Ezaminer, must be notified at once.	<u>a</u>	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Wa	s Decedent of His es, specify Cubar	spanic Origin? (	Specify Yes or No-	14. Race - A White, e	merican Indian, Black,
F 5 11 F	Funeral	1 X Never Married 2 Married	1 Yes 2 X No		_		,	Specify:	White
5-0036 led within 72 hours afte Hygiewic other than "natural", the Medical Examiner	⋧┞	3 Widowed 4 Divorced  15. Decedent's Education (Specify of	If Yes, Give Year or Dates:		Yes 2X No		work done	16b. Kind of Busin	ess/Industry
6 3	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	ost of working life	DO NOT use re	etired)		
036 vithin ene. er tha	ĒĹ	12th grade	8yrs+	Res	earche				ity of MD
15-C		17. Father's Name (First, Middle, Last Robert A. Joh)					ne (First, Middle, Manne Pau)		
- P = 8 - 2	e Be	19a. Informant's Name/Relationship (		19b. Mailing	Address (Stre	et and Number o	r Rural Route Numb	er, City or Town,	State, Zip Code)
	-	Robert A.John							NC 28451
imore, MD 2 Pages 1 and 2 shoul nent of Health and h or other traumatic		20a. Method of Disposition  1 Bunal 2 X Cremation 3		Place of Dispos crematory or oth	ition (Name of ce ner place)	emetery,	Date	20c. Location - Ci	ty or Town, State
Page ment o tant:	1	4 Donation 5 Other Specify	<i>c</i> .	On-Sit			29/09	Baltim	ore, Md
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumant.		21. Signature of Funeral Service Lice	nsee Day M	Ma	rch F/	s of Facility H West	- 1.		
Physician \		23a. Pa ( I. Enter the disease, or com	plications that caused the death	Do not enter t	ne mode of dying	asn Avo , such as cardiad	or respiratory arre	t, shock, or heart	Md 21215 Approximate Interval Between Onset and
/Medical yaminer	V	f ure. List only one cause on e Immediate Cause (Final disease a	ach line. .Anaphylactic 1	resacti	on compl	icating	asthma		Death
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	ے  او	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence o	f):					
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ficate be g physicist the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg	nancy		Ectopic preg		23d. Date of de Month	elivery Day Year
Box 687; death certific	Physician/	past 12 months?	4 Pregnant at time of de		her (Specify)				
Bo he deat the at hed for	Š	1 Yes 2 No 9 V Unknow	3 DINIOWI	things in the c	undorfuine eque	given in Part I	23e Did to	hacco use contribi	ute to the cause of death?
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e law re has b	힐						_ autops perfor 1 ✓ Yes	med? de	or to completion of cause of ath?  Yes 2 No
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Vita hysicia this ce	lo Be	examiner? 1 ✓ Yes 2 No	Hospital: 1  Inpatient 2 ✓	ER/Outpatien	3 DOA	Other: Nur		Residence 6	Other:
of Vital Records, ling Physician: The law required this certificate has been if After this certificate has been if fineral director, page 2 should		27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of	· · · · ·	ury at Work?	28d. Describe reporte	dly injury occurred dly inje substan	subject cted an
ISION Attend or death. rector: by the f	<u></u> 譲	Natural 5 Pending 2 X Accident Investiga	9/27/09	1847 h	cs	Yes 2 X No			or Rural Route Number, City
Division of Vital Records, spital or Attending Physician: The law requirements after death.  In or After this certificate has been sy filled in by the funeral director, page 2 should be a filled in by the funeral director, page 2 should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a shou	Certification:	3 Suicide 6 Could no determin			et, factory, office	building, etc.	or Town, S	tate) er St. B	altimore, MD
To the Hospital within 24 hours a To the Funeral completely filled		4 Homicide  29a. Certifier 1 Certifying Physic	cian: To the best of my knowled	lge, death occu	rred at the time,	date and place, a	and due to the caus	e(s) and manner a	s stated.
To the Hos within 24 h	Medical	one) 2 Medical Examine	er:On the basis of examination a and manner stated.	and/or investiga	tion, in my opinic	on, death occurre	d at the time, date	and place, and du	e to the cause(s)
F = F 0	Ĭ	29b. Signature and title of certifier	L			nse number			d (Month, Day, Year)
		(alre	11	7		.M.E. 		September :	
		<ol> <li>Name and address of person who Zabiullah Ali, M.D. Ass</li> </ol>	completed cause of death (hen sistant Medical Examine)		n Street, Ba	Itimore, MD	21201		
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure,					
Registr	_	0CT 0 1 2	009 Benevas	A. Ma	aklad				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. i 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year **Physician** A. Johnson 09:00 AM Warren 09 2009 22 /Medical **Examiner** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Hospital Baltimore <u>Union Memorial</u> If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X**] M 2□ F Months 57 Director MD 217-56-8093 11**-**6-1951 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f show event, the Mcdigal Examination of the profiled at 1 XYes 2 □ No Directo N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1730 Wolfe Street 21213 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Be Completed by Specify Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 12th grade N/ permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry A. Johnson Dorothy Banks ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

A VORUS Ralto, MD 21213 19a. Informant's Name/Relationship (Type. Print) Rosetta Marks -Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenmount 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9-30-2009 Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) East F/H 21. Signature Funeral Service Lines March 22. Name and Address of Facility MD 21202 Balto, 1101 E. North Avenue 23a. Part 1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia **Physician** 2 weeks /Medical resulting in death) Due to (or as a consequence of): Examiner Severe Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last week Examine Due to (or as a consequence of): The law requires that the death certificate be executed ling physician and e as the burial-trans Years Lung Cance Due to (or as a consequence of): Physician/Medical led by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed cate has been a 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1XYes 2□No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient this ဥ 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death Certification: 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: Director: A ā n 24 hours af in Funeral Dietely filled in

> 5 State Registrar

cal

Medi

DHMH 17 Rev 1/2001

within 2 To the

Registrar's Signature

and manner stated

MD

MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

6 □Could not be

DIMME

Mozayan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signature and title of certifier

Mansoor

31. Date filed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

210 E. University Parkway

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 09-22-09

U.M.H. Baltimore MD 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 200 3:00 PM btember Rita R. Killian 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Mone Square Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs 5. Social Security Number In yrs. last birthday) Vear) Days Months Hours 1 □ M 2 K F 78 219 32 3408 03/20/1931 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Baltimore Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21225 U.S.A. 6050 Ritchie Highway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌡 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 K No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry A. Smuck Thelma Prodoehl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21225 Donald Killian / Husband 6050 Ritchie HIghway 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 10/05/2009 Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final serous disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 DUnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🕱 No 3 🗇 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Date of Injury (Month, Day, Year) 1 Yes 2 No 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a, State

Director

Funeral

Be Completed by

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

**Funeral** 

Director

Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evanirms must be notified at

1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 Is marked other than "natural", or ite

Pages 1

Maryland 21215-003

law requires that the death certificate be executed burial-tran and attending physician for use as the buria detached signed by i page 2 should

Box 68760.

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Records,

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Division of

To the

funeral director, this

Hospital or Attending within 24 hours after death.

To the Funeral Director: A filled in by the completely

> State Registrar

DHMH 17 Rev 1/2001

Date filed (Month, Day,

27. Manner of Death

1 Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending

investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

Year)

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c

Injury at Work?

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

NO

Franklin

1 ☐ Yes 2 ☐ No

Ticense

Square on

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Kucheravy 09 0344 Phyllis Mae /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Peninsula Regional Medical Center Salisburg Dicomico If Under 1 Year | If Under 24 H/s. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🔀 F 217-34-4893 70 Director February 27, 1939 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f shovevent, the Medical Exemitant in ust be neithed at 1 ☐ Yes 2X No Director Maryland Wicamico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4282 Ramblin Road 21804 United States by Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Yes 2X No Saltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 h Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic some Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Smuck Doris Barker ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris A. Weems/ Sister 4282 Ramblin Road, Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery Baltimore, Maryland 4 Donation 5 Other (Specify) 2009 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician AMPROSCIPVING Cardinascentar disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for se a consequence of be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical The law requires that the death certificate use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atter for u 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) signed by the a ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 2 No certificate 1 □Yes 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral Di completely filled in 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

P.O. I of Vital Records, Division To the Hospitai

> State Registrar

Medical

29a. Certifier (Check only one)

Mayosn

29b. Signature and title of certifier

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and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 32014

29d. Date signed (Month, Day, Year)

504 B SALISTON MD 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perINF, G896, 1078/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 **Physician** Keitt Jr. 29 09 4:15p. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Milford Manor Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 01 07 9. Birthplace (State or Foreign 5255**6**1_352:iii31314159 **Funeral** Year) Months Days Hours Min. 1 □XM 2 □ F <del>250-33-3245</del> Director SC 84 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Modical Evantical must be notified at once. 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 3492 Dolfield Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√□No Specify þ Specify: 3 X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lee's Furniture <u>Delivery Truck Driver</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sophie Ammons James Keitt Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3492 Dolfield Ave, Baltimore, Md 21215 Fannie Gwaltney-Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Ponation 5 □ Other (Specify) King Memorial Park 10/5/09 Woodlawn, Md 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Part . Enter the disclase, or complications that cause that death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fina disease or condition resulting in death) **Physician** Atheroiden hi Earlovakence /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, If any leading to time classe cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to or as a consequence of sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No Division of Vital 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30/29 D4768 3 Mul 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Raymore

Mil

31 Date filed (Month, Day, Year)

Street

32. Registrar's Signature

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MO

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			State of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department / Department / Department / Department / Department / Department		lental Hygie	ene	21162
			Registrar  1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg 2. Date of Death	ı. No.	3. Time of Death
	Physici /Medic		Mary Manerva Kharim		Month Sept. 14	Day Year 1 . 2009	6:45 pM
Safe Control	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	,
3000		Ш	Futurecare Homewood	Baltimore			/A
	Funeral Director		5. Social Security Number 6. Sex 1 M 2X1 F 7. Age (In yrs. last birthday) 9 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	'ear) Cou	place (State or Foreign htry) ryland
	pu ,		Usual Residence of Decedent				0d. Inside City Limits
	// // // // // // // // // // // // //	jo	10a. State   10b. County   10c. City, Town or Lo	Baltimore			1 X Yes 2 □ No
	h the h	irect	10e. Street and Number	10f. Zip Code	10g	J. Citizen of What Cou	ntry?
	ath wil	ral	1535 Kennewick Road	21218		USA	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show Jeal Evanther must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	etc.
21215-0036	hours tural"	Completed by	3 ☐ Widowed Wirorced Fear or Dates:  15. Decedent's Education 16a. Dece	dent's Usual Occupation	16	bb. Kind of Business/In	Lack
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121	e filed within the Hygiene.  other than vent, the hone.		10th Grade	Homemaker	(P** - 1   8 8 - 1 - 1   - 8 8 -	Own Ho	ome
Maryland	o g ≅ p	To Be	17. Father's Name (First, Middle, Last)  James Justice		e (First, Middle, Ma. Burns	iden Surname)	
	12 s tha 7 is	. 8		ng Address ( <i>Street and Number or Run</i> 7 Westfield Ave			
Baltimore,	8 5 = 0		Till Buriai 22 Premation 3 Li Hemoval from State	osition (Name of matory or other place)	71 09 20	oc. Location - City or To	·
altin	₽ ± ± = -	13	1 1 22	2. Name and Address of Facility Ch	211		
Ä	Depar Impo any Ir	1	Culler Carres	4210 Belair Roa	d Baltir	more, MD	21206
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):	ter the mode of dying, such as cardiac	-	Disease	Approximate Interval Between Onset and Death
8760,	ficate be executed  physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, reading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c				
O. Box 6	death certi e attending d for use a	Physician/Med		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv	ery Day Year
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Division of Vital Records,	The law rec cate has bee	Completed	Blied End Stage Re	'nal Disease	24a. Was an autopsy performe	prior to co eq? death?	opsy findings available impletion of cause of
ital		Be C	25. Was case referred to medical	26. Place of Deat	1 ☐ Yes 2 h (Check only one)	XNo 1 □ Yes	2 <b>X</b> No
) t	Physician: r this certific ral director, p	ToE	examiner? 1 ☐ Yes 2 No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	nt 3 DOA Other: 4 Nursing Ho	ome 5 🗆 Residenc	ce 6 ☐ Other (Spec	fy)
on c	ding P	ion:	27. Manner of Death  1 Natural 5 □ Pending (Month, Day, Year)  1 Interview of Death 28a. Date of Injury (Month, Day, Year)	f 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how	injury occurred	
)ivisio	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str		28f. Location (Stree City or Town,	et and Number or Rui State)	al Route Number,
_	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical Ce	29a. Certifier  (Check only  Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place, ivestigation, in my opinion, death occur	, and due to the cau rred at the time, date	use(s) and manner as e and place, and due	stated. o the cause(s)
	Fo the vithin to the comple	Mec	one) and manner stated.  29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month)	Day, Year)
			PHYSICIAN	D 5754:	3	9-30-	9
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, P : SANDHV, MD 1940 W. BAL	Print) TIMURE ST. BA	LTIMOR	E, mo 21	223
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 0 1 2009  32. Registrar's Signature	P		•	

DHMH 17 Rev 1/2001

amend #8 Per Ett G896 10/06/09 III 1 - State Amend #1, per MD g902 4/8/10 TF Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) Margarita Lopez Ochoa 2. Date of Death 3. Time of Death Physician/ Lopez -September 2:10 p M Margarita Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4427 Declaration Circle Belcamp Harford . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country). Mexico 7. Age (In vrs. last birthday) 8. Date of Birth 1917 Funeral Hours 1 M 2 F (Month, Day. October 17 Director 92 Yrs 450-62-4263 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Canutillo 1 Yes 2 No El Paso Texas 10e. Street and Number 10c. Citizen of What Country? Funeral 79835 United States 7160 Rio Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 X Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1X Yes 2□No Specify: Mexican Specify: White "natural" 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental 2 Mariana Lopez Ochoa Lopez Aguilar Jose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4427 Declaration Circle, Belcamp, Maryland 21017 Irma Canizales/ Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot September 30 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Klingtor disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 L retail 300.
Pregnant at time of death in the past 12 months?
1 Yes 2 XNo Month Dav Year signed by the a 9 | Linknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 👿 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 🗌 No Yes 2 K No 1 Tes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 X No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte 5 Pending Natural 1 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🌠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Numse Prantioner: To the best of my knowledge, death onturned at the fine, date and place, and due to the 29b. Signature and title of certifier completed. ause of death (Item 23a) (Type, Print) evedo, mi ay, Year Date filed (Month. State Registrar

Box 68760

Division of Vital

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 2:05 P M September 27, Bernice Mae 2009 Leary /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Tate House Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 X F Director Nov 23, 1935 Maryland 216-32-4308 73 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show notified at 1X Yes 2 ☐ No Directo 28a-f Anne Arundel Severn Maryland| permit. Pages 1 and 2 should be filed within 72 hours after death with the I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a any injury or other traumatic event, the World's Exa. in any to result to energy. 10e. Street and Number 10g. Citizen of What Country? Funeral 7750 Twin Oaks Road 21144 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 □Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Addison Howard Anna Amelia Oberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7750 Twin Oaks Road Severn, Maryland 21144 Edward W. Leary/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Epiphany Epis. Ceme. 9/30/2009 Odenton, Maryland re of Funeral Service L 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. <u>1411 Annapolis Road</u> Odenton, Maryland 21113 Homas 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) P.0. ed by the a detached f 1 Tyes 2 Min 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ZYes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy 2 **N**o 1 ☐ Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Have 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and 29d. Date signed (Month, Dav. Year) 29,2009 se of death (Item 23a) (Type, Print) Name and address of person who completed. Oakuroc **ETEIL** 1871

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 29 2009 **Physician** Edward Lowery W. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel County Glen Burnie 338 Gatewater Court Apt. 104 If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Year! 1 X M 2□ F 29,1946 62 Director 218-44-1730 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evancial mist be notified at 10c. City, Town or Location 10a. State 10b. County Directo Anne Arundel Glen Burnie Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 338 Gatewater Court Apt. 104 21060 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (Ā'Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 N/A Carpenter Local 101 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Edward C. Zelma Lowerv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Diana L. Fitzwater (Personal Rep.) 338 Gatewater Court Apt 202 Glen Burnie, Maryland 21060 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory : 09/30/09 Baltimore, Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licensee 3204 Mountain Road Pasadena, Maryland 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Immediate Cause (Final Physician conco luna disease or condition resulting in death) /Medical Due to (or as an sequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records. Completed by

23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2 No 1 ☐ Yes 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 \sum Nursing Home 1 Yes 21 No Hospital: 5 Residence 6 □ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 2 Accident 5 Pending 1 □Yes 2 □ No investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title, of certifier D057936 cause of death (Item 23a) (Type Print) zere St. Partimore MD 21201. 30. Name and address of pers

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Рм

3:30

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 → No

Pennsylvania

White

State Registrar

Be

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Certification:

Medical

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Division of

after death.

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32. Registrar's Signature

	p.	Registrar  1. Decedent's Name (First, Middle, La	8 State of Maryland 10768	Timouto or Boatin	2. Date of Death	3. Time of Death
hysici		Christine	19	CConnell	Septem be	
/Medic Examin		4a. Facility Name (If not institution, give	e street and number)	4b. City, Town, or Location of Deat	h 4c	County of Death
		The Johns Hopkins H		Baltimore City  If Under 1 Year If Under 24 Hrs	Date of Birth (17/17)	N/A R/1967 a Birthplace (State or Foreign
eral tor		5. Social Security Number 6. 321–66–7422	Sex 7. Age (In yrs. last birthda) Yrs.	Months Days Hours Min.	(Month, Day, Year)	3/1962 9. Birthplace (State or Foreign Country) 111inois
4		Usual Residence of Decedent				
	2	10a. State 10b. County	10c. City, Town or I			10d. Inside City Limits 1 √ Yes 2 □ No
	Director	Maryland Baltimo  10e. Street and Number	re City Baltimon	re 10f. Zip-Code	10a, Cit	izen of What Country?
		523 Chapel Stree	s <del>t</del>	21231		USA
	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S     If Yes, specify Cuban, Mexican, Puer		14. Race - American Indian, Black, White, etc.
	by Fu	1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ▼ No If Yes, Give	1 ☐ Yes 2 → No Specify:		Specify: White
		15. Decedent's E		cedent's Usual Occupation		Kind of Business/Industry
ĺ	plet	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) (Giv	ve kind of work done during most of wo . DO NOT use retired)	orking	
	Completed	Elementary/occorridary (0 12)		otographer		Photography
	Be (	17. Father's Name (First, Middle, Last,			ame (First, Middle, Maide	n Surname)
	ျ	Howard James McC		Anne illing Address (Street and Number or R	Axelson	or Town State Zin Code)
		19a. Informant's Name/Relationship  Carla McConnell/		Woodland Drive P		0545
	ŀ	20a. Method of Disposition	20b. Place of Dis			ocation - City or Town, State
		1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the	Removal from State Metro Cr	rematory or other place) Septementary, Inc. 20	ember 30, 200. L 2009 Bal	timore, Maryland
<u>8</u>		21. Signature of Funeral Service Liver	nsee	22. Name and Address of Facility	Of Maryland	Tno
ouce		- alece ss	Alice Iser	22. Name and Address of Facility Fremation Society 199 Frederick Road	Baltimore,	'Maryland 21228
n al er	ical Examiner	disease or condition resulting in death)  Sequentially list conditions, line cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):	nal hemorrhag	e	
	Ö		- ·			
	Medic			-		
	hysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		3  Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1  Yes  No 9  Unknown	1 Live birth 2 Fetal death 3 4 Pregnant at time of death	5 Other (specify)	1	Month Day Year use contribute to the cause of death?
	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1  Yes  No 9  Unknown	1  Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown	5 Other (specify)	1	Month Day Year use contribute to the cause of death?
	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1  Yes  No 9  Unknown	1  Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown	5 Other (specify)	1 ☐ Yes 2	use contribute to the cause of death?  24b. Were autopsy findings available prior to completion of cause of
	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1  Yes  No 9  Unknown	1  Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown	5 Other (specify)	1 ☐ Yes 2	use contribute to the cause of death?  24b. Were autopsy findings available prior to completion of cause of death?
	Be Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown  contributing to death but not resulting in the	e underlying cause given in Part I.	1  Yes 2  24a. Was an autopsy performed? 1  Yes 2 N	Month Day Year  use contribute to the cause of death?  2
	To Be Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1	1	e underlying cause given in Part I.  26. Place of De lient 3 DOA	1  Yes 2	Month Day Year  use contribute to the cause of death?  24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
	To Be Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1   Yes 2 No 9   Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1   Yes 2 No  27. Manner of Death 1 Natural 5   Pending	1	e underlying cause given in Part I.  26. Place of De ient 3 DOA Other: 4 Nursing I a of 28c. Injury at	1   Yes 2  24a. Was an autopsy performed? 1   Yes 2   N  ath (Check only one)  Home 5   Residence	Month Day Year  use contribute to the cause of death?  24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
	To Be Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Yes No  27. Manner of Death	Live birth   2   Fetal death   4   Pregnant at time of death   5     9   Unknown	e underlying cause given in Part I.  26. Place of De  ient 3 DOA Other: 4 Nursing I  e of 28c. Injury at  Work?  M 1 Yes 2 No	1   Yes 2  24a. Was an autopsy performed? 1   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 3   Yes 4   Yes 5   Yes 4   Yes 5   Yes 5   Yes 5   Yes 6   Yes 6   Yes 6   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7	Month Day Year  use contribute to the cause of death?  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  ury occurred
	Certification: To Be Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1   Yes   No    27. Manner of Death   1   Yes   No   28. Accident   3   Suicide   6   Could not determined    29a. Certifier   1   Certifying P	Live birth   2   Fetal death   4   Pregnant at time of death   5     9   Unknown   Contributing to death but not resulting in the contributing to death but not resulting in the contributing to death but not resulting in the contributing to death but not resulting in the contributing to death but not resulting in the contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   Contribution   C	e underlying cause given in Part I.  26. Place of De ient 3 DOA Other: 4 Nursing I of 28c. Injury at Work?  M 1 Y Y Y Yes 2 No street, factory, office	1 ☐ Yes  24a. Was an autopsy performed? 1 ☐ Yes 2 Nath (Check only one)  Home 5 ☐ Residence  28d. Describe how injute  28f. Location (Street & City or Town, State)  2e, and due to the cause(	Month Day Year  use contribute to the cause of death?  2 10 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  ury occurred  and Number or Rural Route Number,  b)  and manner as stated.
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completely liled in <b>by</b> the fulletal director, page 2 should be detached for use as the buriantalish	Certification: To Be Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1   Yes   No   9   Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1   Yes   No   No    27. Manner of Death   1   1   1   1   1   1   1   1   1	Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown	26. Place of De ient 3 DOA Other: 4 Nursing I of y M 1 Yes 2 No street, factory, office  26. Place of De Other: 4 Nursing I of Y M 1 Yes 2 No street, factory, office  27. License number RES COO De, Print)	1 ☐ Yes  24a. Was an autopsy performed? 1 ☐ Yes 2  Path (Check only one)  Home 5 ☐ Residence  28d. Describe how injuited a control of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the cou	Month Day Year  use contribute to the cause of death?  24b. Were autopsy findings available prior to completion of cause of death?  24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No  6 Other (Specify)  ury occurred  and Number or Rural Route Number, and place, and due to the cause(s)  at e signed (Month, Day, Year)

DHMH 17 Rev 1/2001

	1	For State Registrar	State of M	laryland		artment rtificate			and M	-	giene Reg. No.	004	
Physician /Medical		James T. Moni	•							2. Date of Dea Sept.	Day 26	2 00°9	3. Time of De 7:45
Examiner	4	la. Facility Name (If not institution,	give street and number	r)				Location	of Death			unty of Death	
		8923 Waltham		t. A	- 4 - 6- 1 4 1		altim	ore	Od Hrs. I	0 D-t- +( Di-		Itimore	
Funeral Director		5. Social Security Number 6  199-09-8791  Usual Residence of Decedent	1. Sex 1. M 2□ F	ge (In yrs. las	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da July 1	5 1919	9 PA	place (State or Fi ntry)
M to	-	10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City L
af sh		MD Baltin	more	Bal	timor	е							1 ☐ Yes 2[
3a or 28a-f sh at be notified al Director	7	0e. Street and Number 8923 Waltham	Woods Ap	t. A		10f. Zip		1234			-	of What Cou	ntry?
d cityglene.  d other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director	2	1. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 ☑ Yes 2 □ If Yes, Give Year or Dates	? ] No		Was Deced If Yes, spec	ify Cuba	ispanic Or in, Mexicai Specify:	n, Puerto I	ecify Yes or No Rican, etc.)		Race - Amer Black, White, pecify: W	
t, the Medical E	-	15. Decedent's (Specify only highest	grade completed)		16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	l Occup k done d e retired	ation during mos	t of workir	ng [	16b. Kind	of Business/Ir	dustry
om that		Elementary/Secondary (0-12)	College (1-4or <b>n/a</b>	5+)		dicato		,			VA	Claim	s Dept.
atic event, To Be C		17. Father's Name (First, Middle, La Charles Thom								(First, Middle, Wolf	Maiden Su	rname)	
other traumatic event, the M		19a. Informant's Name/Relationship Alison Schunk/								l Route Numbe thervill			
y or othe	2	20a. Method of Disposition  1 ☐ Burial 2 ☐ remation 3  4 ☐ Donation 5 ☐ Other (Spe		7 I		osition (Nam matory or ot Crem				ate 2009		tion - City or T	own, State
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the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, University of it jury that initiated events resulting in death) Last	c	s a conseque									
n/Me		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal d at time of dea	leath 3	⊒Ectopic pr ⊒Other ( <i>sp</i> e		у			230	d. Date of deliment	very Day Yea
should be detached for leted by Physicia		Part II. Other significant condition	s contributing to death	but not resulti	ing in the u	nderlying ca	ause give	en in Part I				contribute to	the cause of deal
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on:	2	27. Manuer of Death  1	the tree	ay, Year)	8b. Time o Injury	М		yat ⟨? Yes 2□	No	28d. Describe I			
Illed in by		4 ☐ Homicide determine	ed 28e. Place of Ir building, e							City or Tov	wn, State)		al Route Numbe
completely filled in by the fu  Medical Certificati		29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the bes caminer: On the basis and manners	of examinatio	edge, deat on and/or in	h occurred a vestigation,	at the tir in my o	ne, date a pinion, dea	nd place, a ath occurre	and due to the ed at the time,	date and pl	nd manner as ace, and due	stated. to the cause(s)
W W	1	29b. Signature and title of certifier				D 29c.	License	e number 7 7 2	7		29d. Date s	igned (Month	, Day, Year)
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DHMH 17 Rev 1/2001

#### 09-07388

Arthur John McCullagh

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

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				No. of				
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		1- For State Registrar		Cert	tificate of	Death		F	Reg. No.	
Physici		Decedent's Name (First, Midd						2. Date of De Month	Day Yea	3. Time of Death
Medical Exami	ner	THE CHAI COM						Septemb	er 22, 2009	0848 hrs
		4a. Facility Name (if not institution 4911 Lasalle Road	on, give street and n	umber)		4b. City, Town, or L Baltimore	ocation of Dea	th	4c. County	of Death
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24H	rs. 8. Date of B	irth(MM/DD/YYYY	9. Birthplace (State or
Director		060-72-3228	1 X M 2 F		58 Yrs	Months Days	Hours M	in. Oct 2	7, 1950	Foreign Country)Ireland
		Usual Residence of Decedent						1000 2	7, 1930	TICIANG
any		10a. State 10b. County		10c. City,	Town or Locati	ion				10d. Inside City Limits
rnd show	卢	MD			Balti	lmore				1 Yes 2 No
Maryland 28a-f show any 1 at once,	ect	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	hat Country?
ith the Maryland 23a or 28a-f sho notified at once	Director	4911 Lasalle	Avenue			2.	1206		US	A
with ms 23 be no	Funeral		ink 12. Was De			s Decedent of Hisp				- American Indian, Black,
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after al", o	by F		orced If Yes, Give Ye or Dates:	ar	1	Yes 2 X No	specify:		Specify:	white
1215-0036 Id be filed within 72 hours after deatt fental Hygiene. narked other than "natural", or ite event, the Medical Examiner must	ed !	15. Decedent's Education (Spe				t's Usual Occupatio ost of working life. I			16b. Kind of Bu	siness/Industry
16 n 72 ] ical 1	Completed	Elementary/Secondary (0-12)		1-4 or 5+)		eer er werking me. E	30 110 1 000 11	, iii 0 <b>u</b> /		
withi	m _C	12	0		mai	intenance				tment store
filed I Hyge of other		17. Father's Name (First, Middle	•			18		•	Maiden Surname	)
21215-0036 vold be filed within 7 Mental Hygiene. marked other than	o Be	Arthur John M  19a. Informant's Name/Relations			10h Mailine	Address (Street		ora Mur		n, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other traumatic event, the Medical Examiner must be notified at once	۲	Nicholas McCul		ther					•	
and 2 and 2 fealth fem 2 frau		20a. Method of Disposition	raagii, bro		lace of Dispos	ition (Name of ceme	etery,	Date	20c. Location -	y, Ireland - City or Town, State
Ore ges 1 t of 1 : If i		1 Burial 2 Cremation	n 3 Removal f	rom State Cr	rematory or oth	ner place)				•
Baltimore, permit. Pages I ar Department of Her Important: If ite		4 X Donation 5 Other S	pecify:		100 1		(F 30)			
Bal permi Depar Impo injur		21. Sign. ervice				ate Anato	my Boan	rd 655 W	. Baltim	ore Street
Physician	-	23a. Nort I. Enter the disease, or	complications that o	caused the death	Do not enter the	ltimore.	MD 213	or respiratory ar	rest shock or he	art Approximate Interval
/Medical		falure. List only one cause	on each line.					or reopiratory at	root, shook, or not	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		a consequence of)		ovascular Dise	ease			Death
		Conventially list conditions	b	a consequence or,						
	횰	Sequentially list conditions, if any, leading to immediate		a consequence of)	):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c	a consequence of)						
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8760, tificate be ng physic as the bur		23b. Was decedent pregnant in the	ne 1 Live		2 Fe	tal death 3	Ectopic pregr	nancy	23d. Date of Month	Day Year
Box 68 e death certi the attendin ed for use a	iğ	past 12 months?		nant at time of dea	oth 5 Oth	ner (Specify)				
Box 687  be death certific  the attending I	Physicia		known g Unkn		-012					
P.O. es that th igned by be detach	by F	Part II. Other significant condit			sulting in the u	nderlying cause giv	en in Part I.			ibute to the cause of death?
S, P.C uires that n signed d be deta	pa	Diabetes mellitus, er	nd stage renal t	ailure						Probably 4 V Unknown
w req	Completed		_					24a. Was auto		Were autopsy findings available prior to completion of cause of
ecc The larate had age 2	Ē								ormed? c 2 ✓ No 1	death?
Vital Rec ysician: The his certificate director, page	a)	25. Was case referred to medica				26.Place o	of Death (Check		-0-3.1-	
of Vital Records, g. Physician: The law require wher this certificate has been si meral director, page 2 should b	B O	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 E	ER/Outpatient	3 DOA O	ther Nurs	ing Home 5	Residence 6	Other: Scene
1 of Jing Ph	=	27. Manner of Death	28a. Date	of Injury h, Day,Year)	28b. Time of Ir	njury 28c. Injury	at Work?	28d. Describe	how injury occurr	ed
Division Isl or Attendii rs after death. al Director: A	Ę	1 ✓ Natural 5 Pend 2 Accident Inves		., 54,, 541,		1 Ye	s 2 No			
ivisiol or Atten after death Director:	ij			ce of Injury - At hor	me, farm, stree	t, factory, office bui	ilding, etc.			er or Rural Route Number, City
Dipital of pital of pital of illed	Certification:		rmined (Specify)	)				or Town,	State)	
Hos 24 ho Fun etely			hysician: To the be							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Exa	miner: On the basis and manner s	of examination and stated.	d/or investigat	ion, in my opinion, o	death occurred	at the time, date	and place, and d	ue to the cause(s)
	Ž	29b. Signature and title of certifie	er		-	29c. License	number		29d. Date signe	ed (Month, Day, Year)
		Men Bra	nd UM	N >		O.C.M	l.E.		September	24, 2009
	İ	30. Name and address of person	· //	se of death (Item 2	23a)					
	_ 1	Melissa Brassell, MD	Assistant Me	edical Examine	er 111 P	enn Street, Ba	ltimore, ME	21201		
		31. Date filed (Month, Day, Year)		egistrar's Signatur	1. par	Kal				
Regist	rar	061 01	2009 De	nova p	1900				_	

OCME

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** 17:58 HENITA SEPTEMBE R 26 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE JOHNS HOPKENS BAYUTEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 X F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Madical Experiment must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. within 72 hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

NUYSES Hill 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) permit. Pages 1 and 2 should be filied wil Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ 19b. Mailing Address (Street and Number Baltimore, 10/2/09 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 Other (Specify) 21. Signature of Funeral Service Licensee AR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SYSTEM OFGAN FAILURE HOUR /Medical Due to (or as a consequence of): Examiner touks ISCHEMIC BOWEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) signed by the a P. 0. 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an Was autopsy performed? has , page 2 certificate 1 **Y**Yes of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) Hospital: 1 Yes 2 □ No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

0 1 2009

ERIC WEIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1940

EXSTERN)

AVENUE

29c. License number

(FS-000

29d. Date signed (Month, Day, Year)

2009

TEMBER

BALTTMORE MARYLAND

		,	1 - For State Registrar	State of Marylan	d / Depa		Health and	-		200	B 3 4 0 0
	Physici	ian	Decedent's Name (First, Middle, I		M - II - m m			2. Date of Month	Death Da	y Ye	
, i	/Medi				McHenr			9	29		
	Examir	ner	4a. Facility Name (If not institution, g		_		or Location of Deat			. County of E	
	Francis		FRANKLIN SQUA  5. Social Security Number 6.	Sex Tospital C		If Under 1 Year	Sedale If Under 24 Hrs	. 8 Date of	Rirth		C ← ← Birthplace (State or Foreign
	Funeral Director		236-32-2544	1□M 2□xF	Yrs.	Months Days	Hours Min.	(Month,	Day, Year)		Country)
	סי		Usual Residence of Decedent	85				Nov.	29,19	923	West Virginia
	ırylan show	_	10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Ba-f	Director	Maryland	Baltimore		Rosed	ale				1 □Yes 2 No
14.	vith th	Dire	10e. Street and Number	1		10f. Zip Code	21237		10g. Cit	tizen of What	t Country?
- Luda	death with the Maryland ms 23a or 28a-f show	Funeral	1507 Cavel Roa	12. Was Decedent Ever in U.	2 10 1	Vac Decedent of I		Specific Veneral	N-		ed States
5 10	ter de inem	Fun	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	Armed Forces?	5.   13. V	Yes, specify Cub	Hisp <i>a</i> nic Origin? (S an, Mexican, Puer	to Rican, etc.)	NO-		American Indian, /hite, etc.
F 98	urs ar al", or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	□Yes 2 No	Specify:			Specify:	White
8-0036	72 ho natur lical	eted	15. Decedent's (Specify only highest g	Education	16a. Deced	lent's Usual Occup	pation during most of wo	rkina	16b. K	ind of Busine	
21	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retire	d)	King	1		
/ 21	led w Hygie her ti		12 Years	24)		Dental A	ssistant		dia Administra	Denta	1
and	l be fi antal F ed ot	Be	17. Father's Name (First, Middle, La					esta Ca	,	,	ماده
henry Maryland	should nd Me mark matie	유	William Penn  19a. Informant's Name/Relationship		19h Mailin	a Address (Street	and Number or R				
	nd 2 s alth ar 27 Is r trau		Mr. Gerald R. M		1	7 Cavel		sedale.		· .	21237
را آو	stal of Hear Item		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of natory or other place	ce)	Date	20c. Le	ocation - City	or Town, State
ກເ Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Madical Examination in the rediffied at once.		1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation / 5 ☐ Other (Spec	Hemovai irom State			Corp. 10	/2/2009	Tot	wson.	Maryland
<u>a</u>	permit. Departr Imports any Inju		21. Signature of Funeral Service Lic		22	Name and Addre					
	89 E 8 9		Regorn	E' Keen			e Ave. I				
			23a. Part 1. Enter the disease, and o shock, or he of failure. List on	mplications that caused the death ly one cause on each line.	. Do not ente	er the mode of dyin	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a. C.O.P.D							Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):						
		P.	Sequentially list conditions,	b Due to (or as a consequ	ence of):						
K	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Disease or linery that initiated events	3							
ó	te be executed ysician and e burial-transit	EXa	resulting in death) Last	Due to (or as a consequ	ence of):						
3760,		ical		d							
89	ertific ling p	Physician/Med	IF FEMALE:								
B _O	attend or us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnanc	су		12	23d. Date of Month	delivery Day Year
Ö	at the de by the tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of do	eath 5L	Other (specify) _			-		
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rds	tuires that n signed I	d by			_			1[	∐Yes 2	□No 3□	Probably 4 Onknown
ဝ	aw requir as been s 2 should I	Completed						24a. W	as an	24b. Were	autopsy findings available
æ	lclan: The lav certificate has ector, page 2 a	шo	***************************************					au pe	topsy rformed?_	prior deat	to completion of cause of h?
<u> </u>	Physician: The this certificate heral director, page	Be C	25. Was case referred to medical	<u> </u>			26. Place of Dea		s 2.⊠No vone)	1 1 1	Yes 2□No
<b>&gt;</b>	hysic nis ce direc		examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 □ DOA Oth	ler: 4 ☐ Nursing H	lome 5 ☐ Re	esidence	6 □Other (a	Specify)
0	r Attending Physiter death. Irector: After this of the funeral director.	Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injui Wor		28d. Describ			
<u>S</u>	Attendl death. ctor: A y the fu	cati	2 Accident investigati 3 Suicide 6 Could not	ho		M 1 🗆	Yes 2 □ No				
Division of Vital Records, P.O. Box 68	al or Attencater death	Certification: To	4 Homicide determine		me, farm, stre	et, factory, office		28f. Location City or 7	(Street ar own, State	nd Number o e)	r Rural Route Number,
	spital ours a leral f		29a. Certifier 1 CertifyIng I	Physician: To the best of my know	vledne death	occurred at the ti	me date and plac	a and due to t	ho causo(s	) and manne	or as stated
. D	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2 Medical Ex-	aminer: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my	opinion, death occi	urred at the tim	ie, date an	d place, and	due to the cause(s)
10	To th Withir To th comp	Me	29b. Signature and title of certifier		/	29c. Licens	se number		29d. Da	te signed (M	lonth, Day, Year)
			VOI	e NOUYER		DO	00650	94	91	29/7	009
			30. Name and address of person wh								
			DR BINH H NGC 31. Date filed (Month, Day, Year)	Lyen 9000	FRANK	Linsa	uare D	R Ba	LTO	md	21237
	Sta Registr		OCT 1 - 2009	32. Registrar's Signat	parko						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 2009 Рм Leon F. Medura /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Joseph Ritchie Hospice Baltimore 3 8 1 8. Date of Birth (Month, Day, Year, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min 214-66-0030 Maryland 56 Director June 29, 1953 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Essex Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 212 North Marlyn Avenue U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: δ Specify: 3 Widowed 4 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) Construction Worker Construction Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Medura 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st. Department of Health and Important: If Item 27 is many injury or other traum 7724 Suitt Drive Pasadena, Maryland 21122 Sharon Morningstar-Sister 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Bayview Crematory 9/29/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee McChily Polyniak Funeral Home, P.A 3204 Mountain Road Pasadena, Maryland 21122 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Carcinoma TONSILEY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) ed by the a detached for 1 Yes 2 No 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t autopsy perform certificate t 2 🗹 No 1 □ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**▼** No After this of funeral dire 1 ☐ Ye,8 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manuer of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO

State Registrar 31. Date filed (Month, Day, Year)

C

P.0.

Division of Vital Records,

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar

Certificate of Death

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Physician
/Medical
Examiner

**Funera** 

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 a or 28a-f show any injury or other traumatic event, The Modical Evantina in ust be notified at aging by once.

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

		1. Decedent's Name	e (First, Middl	e, Last)								2. Date of			3. Time	e of Death
Physici		Giuseppa	Natal	۵								Month	mber		0 10 0	15 A ^M
/Medio		4a. Facility Name (/			and numbe	nr)		4b. City.	Town, o	r Location	of Death	sepre		County of Deat		13 A
Examili	ier	2129 Cha				-,		,,	_	onsvi				Baltim	ore	
uneral		5. Social Security N		6. Sex	7.7	Age (In yrs. i	last birthda	) If Under	1 Year	If Under	24 Hrs.	8. Date of	Birth	9. Birt	hplace (Sta	te or Foreign
irector		058-40-50	016	1 □ M 2	⊠ F	94	Yrs.	Months	Days	Hours	Min.	June	Day, Year)	915	untry) Ital	V
		Usual Residence of										Odire		717		
how	_	10a. State	10b. County				y, Town or I									e City Limits
ga-fs	cto	Maryland	Balti	more		Cat	onsvi	ITe							1 □ Y	∕es 2 🙀 No
or 28	Director	10e. Street and Nur	mber					10f. Zip	Code				10g. Cit	izen of What Co	untry?	
238		2129 Cha	intilla	Road					212	28				USA		
tems	Funeral	11. Marital Status			s Deceder ned Forces	nt Ever in U. s?	S. 13	. Was Deced If Yes, spec	lent of H	lispanic Or an, Mexica	rigin? (Sp n, Puerto	ecify Yes or Rican, etc.)	No-	14. Race - Ame Black, White		1,
o E	by F	1 ☐ Never Marri		lf Y	]Yes 2 es, Give			1 □Yes	No.	Specify.	:				White	
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Department of health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evancibut must be notified at once.	Completed	Elementary/Seco	ndary (0-12)	Co	llege (1-4o	r 5+)	l _	amstre		2)				Cloth	ino	
other sther ent, I	Be C	17. Father's Name	(First, Middle,	Last)				amo er e		18. Moth	er's Nam	e (First, Midd	dle, Maiden		111g	Y - W
ked o	To B	Angelo	DiBias	si						Elvi	ra R	iccia	di			
mar	-	19a. Informant's Na	ame/Relations	hip (Type. Pri	nt)		19b. Ma	ling Address	(Street					or Town, State, 2	Zip Code)	
alim a 27 is 27 is r trai		Rosa Mar:	ia Fab	i	Daugl	nter	2129	- - Chant	· ·111	a Roa	d: C	atons	7111e	MD 212	28	
item othe	-	20a. Method of Disp						oosition (Nan				Date		ocation - City or		•
nt: If ryor		1 🖾 Burial 2 [ 4 🗆 Donation			I from Stat			f. Ceme			10/3	/2009	Har	tsdale,	New '	York
oorta / inju		21. Signature of			765	11		22. Name an	d Addre	ss of Facili	tySte	rling	Ashto	n Schwa	b Wit:	zke
Impo any ii		X L	lo.	16	(L)	4/2	_ F	uneral	Hor	ne of	Cat	onsvil	le, I	nc. ille, M		
		23a. Part 1. Enter the shock, or hea	he disease, or	complication	that caus	ed the death	n. Do not e	nter the mod	e of dyir	ng, such as	cardiac	or respirator	y arrest,	1112, 1	Approxir	
/sician		Immediate Cause (	(Final	only one caus	se on each	lille.	1 .		1	160	1001	1000	1	Linde		nd Death
ledical		disease or condition resulting in death)	n	a	Due to (or a	as a consequ	ue né of):	1	4	M. Con	- WY	000	76-10	/		
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	ner	Sequentially list con any, leading to in cause. Enter Unde	nditions, mediate	D	lus lu (ur t	is a consequ	ience of).			1	1		1.1.	7 04 0		
nd ransi	Examiner	Cause (Disease or that initiated events	injury	с												
attending physician and for use as the burial-transit		resulting in death) L	_ast		Due to (or a	is a consequ	uence of):									
hysic the bi	an/Medical			d					_							
ing p	Mec	IF FEMALE:												'		1.7
ttend or use	an/	23b. Was decedent	pregnant			ne of pregna 2  Fetal		☐ Ectopic p	regnand	:y			- 4	23d. Date of del Month	livery Dav	Year
the a	sici	1 ☐ Yes 2	<b>1</b> 00		Pregnant Unknowr	t at time of d	eath 5	Other (sp	ecify) _				-	MOUTH	Day	real
d by etach	Physic		loont conditi	ann acmtribusti		but mat you	oldin or in the o			aa ia Danii		22a Di	id tobasas	una aantrihuta ta	the source	of dooth?
signe be d	ğ	Part II. Other signif	icant conditi	ons contributii	ig to death	but not rest	illing in the	underlying ci	ause giv	en in Parti	1.			use contribute to	1	100
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has b e 2 sl	Completed											24a. W	itopsy 🧳	24b. Were au	topsy findin	
cate l	ပ္ပြ											pe 1 □ Ye	erformed!/ s \DNo	death? 1 ☐ Yes	2 🗆 No	
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this o	ျှ	1 ☐ Yes 2 🗙		Hospita	1 🔲 Inpa			ent 3 DC		4 ⊔ N	ursing Ho			6 □Other (Spe	cify)	
After	ioi	27. Maurier of Death	5 Pendin	g	. Date of Ir (Month, L	njury D <i>ay, Year)</i>	28b. Time Injury		8c. Injur Wor	k?		28d. Describ	e how inju	ry occurred		
the t	cat	<ul><li>Accident</li><li>3 ☐ Suicide</li></ul>	investi 6 ☐ Could	not bo	DI (1			M		Yes 2	No					
Direction by	Certification:	4 ☐ Homicide	determ	nined 20e	building,	etc. (Specify	me, iarm, s	treet, factory	, office			City or	n (Street ar Town, State	nd Number or Ru e)	irai Houte N	Number,
filled		29a. Certifier	1 Certifyir	ng Physici <i>a</i> n:	To the be	st of my kno	wledne de	ath occurred	at the ti	me date a	nd place	and due to t	he cause/	s) and manner as	s stated	
To the Functor Briestor. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical		2 Medical	Examiner: O	n the basis d manner	of examina	tion and/or	investigation	in my o	pinion, de	ath occur	red at the tin	ne, date an	d place, and due	to the caus	se(s)
<b>To th</b> Somp	Me	29b. Signature and	title of certifie	r/		r		290	. Licens	e number			29d. Da	ite signed (Monti	h, Day, Yea	r)
		▶/		11	11	ah	2661	<	0	29	71	9		10/1	119	1
		30. Name and addre	ess of person	who complete	ed cause of	death (Item	23a) (Type	e, Print)	1	- 1		//	100		21	850
		mor	Lelm	D.	1911		ing	51	60	N-	RVI	lin	1201	Bud	1. 1	
Sta	te	31. Date filed (Mont	th, Day, Year)	0000	32 Degis	strar's Signa	ture	1				1		4 10VA	v - V	/ \
Registr	ar		16 111	2003	1200	Cint.	A. A.	3 taker	P"			_	-			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Carmela Neighoff Sebtember 2 Za /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner oseda 1are If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number ge (In yrs. last birthday) **Funeral** Months Hours 1 □ M 2 🖫 F 83 Director 220-12-5833 13,1925 Connecticut Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show or than "natural", or items 23a or 28a-f shov Perry Hall 1 ☐Yes 2 X No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21128 United States Funeral 9905 Richlyn Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black White etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or Maryland 21215-0036 1 ☐Yes 2 No ģ Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injur or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 9 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Scichetano Rosemarie Nistico ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9905 Bichlyn Drive Perry Hall, Maryland 21128 Carmela Vargo (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 DeBurial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 10/2/2009 Dundalk, Maryland 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Lice 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. mediate Cause (Fi al **Physician** disease or condi-resulting in death) /Medical Due to (or as a consequence of) Examiner comestive Heart Failure S. ... nicely is a continuous if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Box 68760, Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Year 5 Other (specify) been signed by the should be detached Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performe certificate 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 15de Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29a, Certifier (Check only one)

29b. Signature and

VASIUADET, M.D

29c. License number

D0064755

Square Drive Baltimore

29d. Date signed (Month, Day, Year)

9/27/09

and manner stated.

			1 - For State Registrar	State of	Marylan	_	artment					giene Reg. No.		- 2 1.1.	. 🕥
	Physici		1. Decedent's Name (First, Middle	(Last)	1.						2. Date of De		Yea Zec	C	м
	/Medio Examin		4a. Facility Name (If not institution,			-	4b. City,	Town, or	Location of	of Death	0 (	4c. C	ounty of De	TO O JOH	
Ġ.	LXamii		Ridgeway Manor	Nursingar	nd Rehab	oi 1 itim	Balti	imore					Baltin	nore	
	Funeral			6. Sex 7.	Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	th ly, Year)	9. B	Sirthplace (State or Fo. Country)	reign
	Director		217-12-7360	1 🔀 M 2 🗆 F	89	Yrs.					Jan no	19	20 Ma	arvĺand	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Li	mits
	Manyl 1 sho	Į.	Maryland D-1.	•		D. 1.								1 □ Yes 2 5	No
	28a	reci	10e. Street and Number	imore		Ватс	imore	Code				10g. Citize	en of What	Country?	
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	ams ?	ner	11. Marital Status	12. Was Decede	357			ent of Hi	spanic Ori	gin? (Spe	cify Yes or No		4. Race - Ar Black, WI	merican Indian,	
36	or It	by Fu	1 Never Married 2 Marrie	ed 1 1 Yes 2 If Yes, Give	□ ^{No} 194	1_	1 □ Yes 2		Specify:		,	5	Specify: W		
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Jicol Examinet must be notified at		3 ☐ Widowed 4 ☑ Divorced	Year or Date	s: 194	5	dent's Usua	**	tion						
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	e filec al Hyg otha vant,	Be C	17. Father's Name (First, Middle, L	Last)						er's Name	(First, Middle,		,	M = M	
<u>la</u>	Menta Menta arkad	To	John Thomas 0'	Connell					Marie	e Rut	h Camp	bell			
Maryland	2 she and is ma		19a. Informant's Name/Relationsh				_				l Route Numbe				
	1 and 1eaith im 27 ther t		Robin Nitsch/ Da	aughter	20h B	3603	Hinel	ine	Road	. Bal	timore	Mar	yland	21229	
Jor	iges if its or of		20a. Method of Disposition  1  Burial 2 Cremation		rre	lace of Dispo emetery, crei				eptei 2∩09				or Town, State	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itams 23a or 28a-1 show any injury or other traumatic avant, the Medical Examinat must be notified at one.		* 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L	**		ro Cre			L.					Maryland	
Ba	permi Depa Impo any is		Smarpell	ush		2.9	9 Fre	deri	ck Ro	oad,	Baltim	ore.		Maryland I and 21228	nc.
	Fhysician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a on eac	as a consequ	٤:	er the mode	e or dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Betweer Onset and Deat	h 1
	cuted id	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	as a consequ	uence of):									
8760,	ate be executed hysician and the burial-transit	ca	resulting in death) Last	Due to (or	as a consequ	uence ot):									
. Box 6	Attanding Physician: The law requires that the death certificate be executed r death. r death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burral-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		2 ☐ Fetal tat time of de	Ideath 3□	Ectopic pre					23	3d. Date of o	delivery Day Year	
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Division of Vital	Attanding Physician: The ter death. sr death. rector: After this certificate he by the funeral director, page	Certification:	1 Natural 5 Pending 2 Accident investig: 3 Suicide 6 Could n	ation	Day Year)	28b. Time of Injury	M	8c. Injury Work 1 🗀 Y	at :? /es 2 ⊟i		28d. Describe l	now injury	occurred		
Σ			4 Homicide determin	ned 289. Place of	Injury - At ho etc. (Specify	ome, farm, str	eet, factory	, office		2	28f. Location (3 City or Tox		Number or	Rural Route Number,	
	To the Hospital or within 24 hours after to the Funeral Dictoropletely filled in	edical	29a. Certifier 1 Certifying (Check only one)	g Physician: To the be xaminer: On the basis and manner	s of examinat	wledge, death tion and/or in	occurred a vestigation,	at the tim in my op	e, date an pinion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) a date and p	ind manner place, and d	as stated. lue to the cause(s)	
	with To t	Σ	29b. Signature and title of certifier				1 -	License	- / -	$\overline{}$				onth, Day, Year)	
			Hilloel de	warul)			- Andrew Present	7)(	966	)		09	-29-	2009	
		0	30. Name and address of a son w		of death (Item	23a) (Type,	Print)		, 4	CF0	a o	- 0	10.10	-2009 en 2006 j	
	Sta	-(	31. Date filed (Month, Day, Year)		strar's Signa	who do	Brand	7/000	7) -	208	gen Ov	rues V	المسال	100/	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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**Physician** /Medical Examiner

**Funeral** Director

Director

Funeral

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Itw Medical Evancinal must be notified at

Maryland 21215-0036

Baltimore,

**Physician** /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed and the attending physician has been signed by the e 2 should be detached After this 24 hours after death Funeral Director:

Division of Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) September 25, 2009 | 12:18 a Μ. Piracci 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Brooklyn Park
If Under 1 Year 1 If Under 24 Hrs Genesis Hammonds Lane Center Anne Arundel Co.

9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Sept 26, 19 1□ M 2 F Days Months Hours Min 214-22-1294 82 1926 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 S. Carey St. 21223 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 Ŋ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify 3 ₩Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Agnes Kaniecki Frank Lewandowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Hafer / Friend 420 Bigley Avenue Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/28/09 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk. 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Hwy. Balto. Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ocerdio disease or condition resulting in death) a consequence of): tens De C Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 █ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Avatural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53465

State

within 2

DAKWOOD

Road Glen Burnie, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2842 32. Registrar's Signature

Muneses

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#18perFH, G896, 1076709, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 11:40 a M Potter Caroline 9 29 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Towson <u>Gilchrist Hospice</u> If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 X F Months Days Hours Min. 89 084-16-9219 28,1920 NY April Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3729 Elm Ave 21211 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname)

Trombly

Ida Brombly 17. Father's Name (First, Middle, Last) Walter Phair 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21211 Baltimore, Pamela Potter-Hennessey/Daulghter 3731 Elm Ave 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State [9/30/2009] 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD Ardent Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services MD 21203 Maisra Box 1413 Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) pungestive Due to (or as a conse uence of): Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy 1 □ Yes 21 🗗 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1∐Yes 2∭XNo Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

that the death certificate be executed o ď. Records, Physician: The law requires Vital ð Division or Attending after death. the Hospital

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

28a-f show

Director

Funeral

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Be Completed

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Physician/Medical Examiner

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Completed

Be

Certification: To

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

27 Is marked other than "natural", or items 23a or 28a-f shou traumatic event, the Modical Even, the formatic event,

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Every Apple.

**Physician** 

/Medical

Examiner

attending physician and for use as the burial-transit

sate has been signed by the attendir page 2 should be detached for use.

this certificate

After

the funeral director.

filled in by

Baltimore, Maryland 21215-0036

the Maryland

with

aroline

To the Funeral

State Registrar 6701N). (

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

and manner stated.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland /	Dep	artmer	nt of	Heal	th and	Mental	Hygien	е
	-							

			1 - State Registrar		Certifi	cate of	Death	Reg	J. No.		
В	byoisi		1. Decedent's Name (First, Middle, La	st)		110		2. Date of Death Month	Day	Year	3. Time of Death
	hysici: /Medic		DORIS	PINNI	CK			SEPTEMB			20:00 PM
E	xamin	er	4a. Facility Name (If not institution, giv	,		City, Town, or	Location of Death		4c. County	of Death	
			JOHNS HOPKINS BAY				IMORE				
	ineral rector		MN LL STOW	Tex 7. Age (In yrs. last b.	" diddy/	onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	926	9. Birthpl	ace (State or Foreign ry)
and	M		Usual Residence of Decedent  10a. State 10b. County	10c, City, Toy	vn or Locatio	n				10	d. Inside City Limits
ne Maryl	8a-f sho	Director	Mb	RaH	LIMORE				-		1 Yes 2 □ No
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	d other than "natural", or items 23a or 28a-f show event, the Madical Examinat must be notified at	ral Dire	10e. Street and Number 4925 Sc.ha W.L	b Avenue	10	of, Zip Code ŽŽ	206	100	g. Citizen of V U	/hat Count	ry?
er dea	tems Net_m	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was I If Yes	Decedent of H s, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, e	
5-0036 72 hours after	ral", or Exami	þ	1 ☐ Never Married 2 ☐ Married 3 Midowed 4 ☐ Divorced	1 □ Yes 2 No If Yes, Give/ Year or Dates:	1 □ Y	es 2 No	Specify:		Specify	Bh	ck
<b>15-(</b>	"natu	lete	15. Decedent's E (Specify only highest gra		(Give kind	s Usual Occup of work done	durina most of worl	ing 16	b. Kind of Bu	siness/Ind	ustry
within iene.	than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ShU A	OT use retired	10	$\mathcal{C}$	ity of	Bal	Limores
filed Il Hyg	other /ent,	Be C	17. Father's Name (First, Middle, Last		0.00	, , , , , , ,		e (First, Middle, Ma	iden Surnam	0)	<i>7. 10.</i> C
arylan should be and Mental		P E	McDonald Brig	9.5			Myrtle	Mamie	Mapi	)	
2 S E	7 is ma traum		19a. Informant's Name/Relationship	type. Print) 19	b. Mailing Ad	Idress (Street	and Number or Ru	ral Route Number,	City or Town,	State, Zip	Code)
	item 27 is marker other traumatic	JI 60	20a. Method of Disposition	20b. Place comet	of Disposition	MM C( Name of Ty prother place	our D	Date / 20	oc. Location -	City or Tov	vn, State
V 5	Important: If any injury or once.		Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Fundar Service Lice	VI) Helloval Holli State Arby	itus i	Cemer me and Addre	ery: 1010	2/2009	WHIMO	rej/	<u>laryland</u>
<b>Balt</b> permit. Depart	any i		21. Signature of the strict Little	na1553	Voug	ihn C	Greene F	SIAITIK	1012 KU	laval	aid ZIZIZ
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do one cause on each line.	not enter Inc	e mode of dyir	ng, such as cardiac	or respiratory arres	t,	9	Approximate Interval Between Onset and Death
Phys /Me	ician dícal		Immediate Cause (Final disease or condition resulting in death)	a Myocansia		LATON					4 DA-15
	niner			Due to (or as a consequence	e of):						3 WEEKS
P		ner	Sequentially list conditions, if any leading to in modal cause. Enter Underlying	b. Due to (or as a donaquenca	inf)						
ecute	and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Saurmons Ce	u w	NG CAN	JUSH				4 MERICS
ox 68 / 60, certificate be executed	sician burial			Due to (or as a consequence	; OI).						
<b>5</b> Cat	g pny as the	Medical		u					L		
<b>BOX</b>	r use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	h 3∏ Ect	opic pregnanc	W			e of delive	
the death	certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown		er (specify) _	,		Мо	nth	Day Year
ords, P.O. requires that the	ned by deta	by Ph	Part II. Other significant conditions	ontributing to death but not resulting	in the underly	ying cause giv	en in Part I.	23e. Did toba	cco use conti	ribute to th	e cause of death?
ord:	d blud							1 ☐ Yes	2 🗌 No	3 Prob	ably 4 🖬 Unknown
The law requires to	as be	Completed						24a. Was an autopsy	24b. \	Vere autoporior to con	osy findings available appletion of cause of
The The	, page	Co						performe 1 □ Yes 2	ed2   0	leath? □Yes	
OT VITAL Physician: T	ector	Be	25. Was case referred to medical examiner?	Hospital:		Oth	or:	h (Check only one)			
Phys		2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☑ Inpatient 2 ☐ ER/O	Outpatient 3 Time of		4 Li Nursing H	ome 5 Residen		_ ` ' _ '	")
nding F	e fune	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury N	28c. Injur Worl	رْ? Yes 2 □No	Edd. Bescribe non	injury occurr	ou	
To the Hospital or Attending within 24 hours after death. To the Enneval Director, After	completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, fa	actory, office		28f. Location (Stre City or Town,	et and Numb State)	er or Rurai	Route Number,
Spital	y filled		29a. Certifier 1 Certifying Pr	ysician: To the best of my knowledg	ge, death occ	curred at the ti	me, date and place	, and due to the ca	use(s) and ma	anner as st	ated.
the Ho	npletel	Medical	(Check only 2   Medical Examone)	niner: On the basis of examination a and manner stated.	ınd/or investi	gation, in my o	pinion, death occu	red at the time, dat	e and place,	and due to	the cause(s)
_ 5 ± 5	00	2	29b. Signature and title of certifier			29c. Licens			d. Date signed		
		-	20. Name and address of access	completed out of death (the case)	/Tue - Poiss		~ 000	5€	PTEMBE	512 2	4, 2009
			30. Name and address of person who				VENUE B	ALTIMORES	, MD	2122	-4
	Sta	te	31. Date/lest (Month, Day, Year)	32. Registrar i Signature	All I						

			1 _ State	State	of Maryla		artment of F rtificate of I		Mental Hyg				
			Registrar  1. Decedent's Name (First, Middle	e. Last)		061	tillcate of t	Jean	2. Date of Deat	eg. No.		3. Time of	Death
ш	Physici		Lorraine	, ,,	р. <del>;</del>	ichardso	· m		Month Septembe	Day	Year		, M
-	/Medio Examin		4a. Facility Name (If not institutio	n, give street and n		LCHarusc	4b. City, Town, or	Location of Deat		4c. County		9:55	_A
	LXamii		5 Briarwood R	oad	,		Catonsv			Balt		,	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yr.	s. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth		9. Birthp	lace (State o	r Foreign
	Director		229-50-3647	1 □ M 2 🖾 F	91	Yrs.	Months Days	Hours Min.	. (Month, Day, Oct. 26	,1917	Cour Mar	yland	
	pu ,		Usual Residence of Decedent		10. (								
	aryla shov	5	10a. State 10b. County			City, Town or Lo					1	0d. Inside Cit 1 ☐ Yes	•
	he M	Director	MD Balt:	Lmore		Catonsv							2 (XINO
	with t	늅	10e. Street and Number				10f. Zip Code		1	0g. Citizen of V	/hat Cour	itry?	
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21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a Medical Examinat must be profilled at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	ied Armed F	Forces? 2 📉 No Bive		Vas Decedent of H fYes, specify Cuba I∐Yes 2 <b>⊠</b> No	Specify:	to Rican, etc.)		k, White,	ean Indian, etc. nite	
2-0	72 ho	jed	15. Deceder	t's Education	n	16a. Deced	dent's Usual Occup	ation	at days	16b. Kind of Bu	siness/Ind	dustry	
21	within 7 iene. • <b>than</b> "r	nple.	(Specify only highe Elementary/Secondary (0-12)		(1-4or 5+)	life. L	kind of work done o OO NOT use retired	during most of wo  }	rking				
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yla	2 should be finand Mental Fismarked of raumatic even	ဥ	George Eberha	TT.				Caroli	ne Schaib	le			
Maryland	2 sh and r is rr raum		19a. Informant's Name/Relations						ural Route Number				
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Baltimore,	ges it of I		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐ Removal fron	i State i		sition (Name of natory or other plac	•	Date	20c. Location -	City or To	wn, State	
ţ	t. Pa rtmer rtant:		4 □ Donation 5 □ Other (S	pecify)	B1a	andford	Cemetery	10/3	/2009 P	etersbu	rg,	VA	
Bal	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service	Licens	1/2	F1	. Name and Addres uneral Ho 530 Edmon	ss of Facility St me of Ca dson Ave	erling A atonsvill enue; Cat	shton S e, Inc. onsvill	chwal e. M	b Witz n 2122	ke 8
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea	ath. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory arre	est,	,	Approximate Interval Bety	9
The same	Physician	Immediate Cause (Final disease or condition Coronary Arritery Disease											eath 4 TS
	/Medical		resulting in death)	a.	o (or as a conse		-					<u> </u>	
	Examiner		Sequentially list conditions	b									
	pe tis	<u>la</u>	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to	(or as a conse	vience of					-4		
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):										
8760,	icate be executed physician and the burial-transit	a E	,	(Of as a conse	equence or).								
		dical		d					·			<del>-</del> .	
×	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, or	utcome of pregi	nancv				and Det			
Вох	leath atter	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fe	tal death 3	Ectopic pregnancy Other (specify)	/		Moi	e of delive nth	*	'ear
P.O.	the c	ιysi	1 ☐ Yes 2 ♠No 9 ☐ Unknown	9 □ Unk									
т. П	uires that the de	by P	Part II. Other significant condition	ons contributing to	death but not re	sulting in the un	derlying cause give	en in Part I.	23e. Did tob	acco use contr	ibute to th	ne cause of de	eath?
Vital Records,	quire	pe pe	Aortic Ste	nosis					1 □ Ye	s 2 No	3 ☐ Prob	ably 4 U	Inknown
ပ္ပ	aw requir is been s 2 should	Completed	Essential	Hyper	tensi	on			24a. Was ar	24b. V	Vere auto	psy findings a	available
æ	: The law cate has page 2 t	E O							autops	red?	eath?	npletion of ca	ause of
<u>ta</u>	ilcian: The certificate ector, pag	BeC	25. Was case referred to medical	1				26. Place of Dea	1 ∐Yes 2 ath <i>(Check only one</i>		□Yes	2 No	_
>	Physician: this certific al director,		examiner? 1 ☐ Yes	Hospital: 1	Inpatient 2	☐ ER/Outpatien	t 3 DOA Othe		lome 5 Reside		er (Snecif	v)	
n of	ding Pł h. After tr funeral	핅	27. Manner of Death	28a. Date	e of Injury nth, Day, Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho			,,	
<u>ö</u>	endil eath. or: A he fu	äţ	Natural 5 ☐ Pendin investig	jation	,,, ,,,	,		Yes 2 □ No					
Division	I or Attend after death Director: d in by the f	Certification: To	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ined Zoe. Flat	e of Injury - At I	home, farm, stre	et, factory, office		28f. Location (Str City or Town	reet and Number State)	er or Rura	l Route Numb	ber,
	pital or ours afte eral Dir filled in				•								),
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, p.	Medical	29a. Certifier (Check only one)  Certifyir  2 Medical	Examiner: On the	e best of my kr basis of examir nner stated.	nowledge, death nation and/or inv	occurred at the ting restigation, in my op	ne, date and plac pinion, death occi	e, and due to the ca urred at the time, da	ause(s) and ma ate and place, a	nner as s and due to	tated. the cause(s)	,
	Vithii vithii Comp	Ž	29b. Signature and title of certifie	2 _ /	2	1.	29c. License	number	29	d. Date signed	(Month,	Day, Year)	
			Sen 2	Mi	um-	MI	DI	9558		09-2	8-2	2009	
			30. Name and address of person	who mpleted cau	ise of death (Ite	em 23a) (Type, F	Print)						
			Glen E. Johnso			<del></del>	oice Lane	, Catons	ville, M	21228			
	Stat	_	31. Date filed (Month, Day, Year)		Registrar's Sign	nature							
	Registra	ir i	UCT 0 f	2009	Carl Branch Son	A. As	BA Plant						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Tyrone Richardso		1- For State Registrar	State of Ma	ryland /		artment of			Menta	al Hy	_	eg. No.			E 0 04 1
Physicia Medical Examir	ın/	1. Decedent's Name (First, Mic	ldle,Last)	RI	СНАБ	RDSON				2	2. Date of Dea Month Septembe	ith	Year 2009		3. Time of Death 0329 hrs
ť .		4a. Facility Name (if not institu 12511 Marleigh Driv		nd number)			b. City, To Bowie	own, or Lo	ocation of	Death			. County of I rince Ge		S
Funeral Director		5. Social Security Number 578-98-9292	6. Sex		(In yrs. I	ast birthday)	If Under Months		If Under Hours	24Hrs.	1			Cou	
<u> </u>		Usual Residence of Decedent 10a. State 10b. Count				Yrs	1				Aug.	24 1	1970		HINGTON, DC
and Show any nce.	٦		y CE GEORGI		BOV	Town or Locati $VIE$	on								10d. Inside City Limits 1 X Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once,	Director	10e. Street and Number	W PRIME				10f. Zip (				1		zen of What	Count	ry?
h with th ms 23a be notif		12511 MARLEIO	12. Was	Decedent E	ver in U	.S. 13. Wa	Deceden	720	anic Origin	n? ( Spe	cify Yes or No	US	14. Race - /		an Indian, Black,
fter deatl	y Funeral	Never Married 2 X  Widowed 4 D	Viairieu	ed Forces? es 2 X e Year	No		es, specify Yes 2			Puerto R	acan, etc.)		White, e	BLA	.CK
2 hours a "natura	ted by	15. Decedent's Education (Special Elementary/Secondary (0-12)		grade comp		16a. Deceden		ccupation	n (Give kii	nd of wo	ork done ed)	16b. K	(ind of Busir	ness/In	dustry
5-0036 led within 7/ Hygiene. other than the Medical	Completed	12TH		90 (1-4010)	,	ENTRE	RENE					1	RIVATE	1	
21 se fill stal F ked	Becc	17. Father's Name (First, Midd JAMES MELV.							Mother's ELLA	,	First, Middle, I CHARDS		Surname)		
MD 21 d 2 should b th and Mer n 27 is mar	욘	19a. Informant's Name/Relation VALENCIA RICHA									OWIE,		-		
imore, N Pages I and nent of Healtl ant: If item or other trau	Ī	20a. Method of Disposition  1 XBurial 2 Cremati			, (	Place of Disposi crematory or oth	tion (Name er place)	e of ceme	etery,		Date		ocation - C		
altimo rmit. Pag spartment sportant: lury or od	0	4 Donation 5 Other 21 Signature of Funeral Service			F	LINCO	LN C								IARYLAND L HOME
	1	23a. Part I. Enter the disease,	or complications th	ast caused th	o doath					ROAD	LANDO	VER,	,MARYI	AND	20785
Physician /Medical xaminer		failure. List only one caus Immediate Cause (Final disease	e on each line.		c deali	. Do not enter tr	e mode of	dyllig, sc	icii as cai	ulac of 1	espiratory arr	est, silo	ick, or near		Approximate Interval Between Onset and Death
		or condition resulting in death)  Sequentially list conditions,	Due to (or b.	as a conseq	uence o	f):									
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be e	ledical	UNPENDED	AMEND		of negati								Data da		
Box 6876( c death certificate the attending physed for use as the b		23b. Was decedent pregnant in past 12 months?	the 1 L	es, outcome ive birth regnant at tir		2 Fet	al death	3	Ectopic p	regnan	су		d. Date of de Month	elivery Da	y Year
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Division of Vital Records, tal or Attending Physician: The law require is after death.  "al Director: After this certificate has been signed by the funeral director, page 2 should be in by the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director.	Completed										24a. Was autop		pric		psy findings available mpletion of cause of
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of Vit	٥,	examiner?  1 ✓ Yes 2 No  27. Manner of Death	Hospital: 1	Inpatient Date of Injury	2	ER/Outpatient 28b. Time of Ir			ther 4 1		Home 5		nce 6		Scene
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	<u>ह्य</u>	29a. Certifier 1 Certifying	Physician: To the aminer: On the ba	best of my k	nowledg	e, death occurr									
FRES	Ĕ	29b. Signature and title of certif		S. S. S. G. G. G.	1	-		License r							h, Day, Year)
0/	3	30. Name and address of person	n who complete	ause of d	(Item	a)		O.O. IVI.	. Ľ.	-		Sep	tember 2	0, 20	U <del>S</del>
Sto	to i	Zabiullah Ali, M.D.	Assistant Me	edical Exa		111 Penr	Street,	Baltim	ore, MI	D 212	01				
Sta Registra	~	OCT 0 1	2009 2	www.	A.	BON									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 300 Mary 26 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Charlestown Retirement Community Catonsville Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 286-18-6105 87 June 19 1922 Indiana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 ☐ Yes 2 No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) n/a Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence George Brown Lois Carmen Ashton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Douglas Roth/son 1802 Eastridge Rd., Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Atlantic Crematory 4 Donation 5 ☐ Other (Specify) Glen Burnie, MD 10/1/09 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093

**Physician** /Medical Examiner Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

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Completed

Be

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within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Opertment of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, If a health Franciscon or other traumatic event, If a health Franciscon must be no filled in

12 should be filed w h and Mental Hygier is marked other th

Pages 1

Saltimore, Maryland 21215-0036

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icate has After thi funeral of within 24 hours after death

To the Funeral Director:
completely filled in by the f

Physician/Medical

Be Completed by

Certification: To

Medical

31. Date filed (Month, Day, Year)

23a. Part 1. Enter the disease, or com shock, or leart falure. List only Immediate Calise (Fig. 1)	_			or respiratory arrest,	J	Approximate Interval Between Onset and Death
disease or con life resulting in death)	a. End-Stag  Due to (or as a conseque		rtia			
Sequentially list conditions, if any, leading to immediate cause. End of underlying Cause (Disease or injury that initiated events	b. Due to (or as a conseque					
resulting in death) Last	Due to (or as a conseque	ence of):		23d. Date of d Month  23e. Did tobacco use contribute  1		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of the pregnant at time of de 9 □ Unknown	death 3 Ectopic p	regnancy ecify)		23d. Date of del Month	ivery Day Year
Part II. Other significant conditions of		, ,	ause given in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
cerebral vasc	ular disea	se		1 ☐ Yes	2 ☐ No 3 ☐ Pr	obably 4 Unknown
				autopsy performed	? _ death?	topsy findings available completion of cause of 2 □No
25. Was case referred to medical examiner?	115201					
1 Yes 2 1√10		Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Resider				
27. Manner of Death  1	(Month, Ďay, Year)	28b. Time of 2 Injury M	8c. Injury at Work? 1 □Yes 2 □ No	28d. Describe how in	ijury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	and Number or Ru ate)	ıral Route Number,			
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my knowniner: On the basis of examinati and manner stated.	rledge, death occurred on and/or investigation	at the time, date and place, , in my opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
29b. Signature and title of certifier		290	. License number	29d.	Date signed (Monti	h, Day, Year)
Deneen	Barlin, n	4) D	44372		1/28/0	09
30. Name and address of person who				•		21228
Deneen Bowlin	, MD 711 Ma	iden Cha	rice Lane	, Caton.	sville,	mo

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** RED W RATC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CROSS SILUBR SPRING If Under 1 Year If Under 24 Hrs. 8. Date of Bin HOSPIT MONTGOMERY 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** 1 MM 2□ F Days Hours Min. Months Director 214-30-055 NWW Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examination materials or nation a 1 Nes 2 No SILVER Director MD MONTGOMERY SPRINC 10e. Street and Number 10g. Citizen of What Country? 901 20902-3401 Funeral ARCOLA AUE APT NWN 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 2 3 ☐ Widowed 4 ☑ Divorced NUN Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -MBOR SERVICE UNK UNK NON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ UNIV NUND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is many injury or other 19a. Informant's Name/Relationship (Type. Print) HOLY CROSS HOSPITAL 55 MD 1500 FOREST GLEN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state 21. Signature of Funeral Service Licensee

Ronald S. Wade

Ronald S. Wade

Ronald S. Wade

Ronald S. Wade

State Anatomy Board 655 W. Baltimore, MD 21201

23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death Physician RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transi CIRRHOSIC NJUER and Due to (or as a consequence of): Box 68760. physician certificate be Physician/Medical ORTAL ENSION as the attending p IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached for P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 I I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>≨</u> SCILE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed HRONI 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No PULMONARY DISENSE 24a. Was an page 2 autopsy performed? Yes 2 100 certificate of Vital 1 □ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this c funeral dire 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: completely filled in by the 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

MAN

31. Date filed (Month, Day, Year)

egistrar's Signatur

SHAH

32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 FOREST

GLEN RD

Donaldk	ICC
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UNK UNK	
	1- For S
	Registr
Physician/	1. Dece

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland 7 Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.	2005 3 4
Physicia	an/	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Y	3. Time of Death  'ear 0135 hrs
Medical Exami		Population of the september 15, 2009 September 15, 2009	ty of Death
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Count Baltimore	y or Boun
Funeral			YY) 9. Birthplace (State or Foreign
Director	-	218801254 <b>X</b> XM 2 F 48 Yrs. Months Days Hours Min. 7-18-1961	Country) MD
	ŀ	2   880   254	
any	-	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
daryland 28a-f show any 1 at once	5	Baltimore	1 X Yes 2 No
Maryla 28a-f 1 at o	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of	What Country?
ith the Maryland 23a or 28a-f sho notified at once			
215-0036 be filed within 72 hours after death with the Maryland mtal Hygiene. rked other than "natural", or items 23a or 28a-f shent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Ra WI	ace - American Indian, Black, hite, etc.
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irs aft ural"	ē	16 December 1 Specific of Work done 16 or Wilder 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work done 16 or Work do	Business/Industry
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0036 within 72 iene. ier than '	Completed	Carpentry self-	-employed
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12 Id be I Aental narke event	o Be		own, State, Zip Code)
MD 21215-0036 d 2 should be filed within 7 tht and Mental Hygiene. n 27 is marked other than numatic event, the Medica	Ħ	Peggy Rice/sister   2620 Miles Ave.Baltimore, MD	1
- m = w		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location	on - City or Town, State
Baltimore, Department of Hee Important: If ite		1 Burial 2 X Cremation 3 Removal from State	ino MD
Baltimo permit. Page Department of Important: injury or ot	1	22 Name and Address of Facility	
E P P E		Charisse Woods Fun Sv3307M	IondawminAv
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or failure. List only one cause on each line.	Between Onset and
/Medical vaminer	- 1	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Death
		b b to to to a solidation of the	
	į	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Examiner	Cuisease or injury that initiated events resulting in death) Last Universe or injury that initiated events resulting in death).	
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Box e death c the atten ed for us	ysi	1 Yes 2 No 9 Unknown 9 Unknown	
<b>∴</b> # ≳5	by P		ontribute to the cause of death?  3 Probably 4 Unknown
ords, P.C w requires that is been signed by should be deta	ed b	24a. Was an 24	4b. Were autopsy findings available
of Vital Records, ng Physician: The law requir wher this certificate has been s meral director, page 2 should t	Completed	ted vide all 24 vide all 24 performed?	prior to completion of cause of death?
Rec The l	등	1 ✓ Yes 2 No	1 Yes 2 No
tal Rec	Be (	25. Was case referred to medical 26. Place of Death (Check only one)	0.4000
F Vi	ို	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Oute 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury oc	6 Other: Scene
n of ading Ph.	ii oi	5 1 Natural 5 Pending Sep 15, 2009 0121 hrs 1 Yes 2 ✓ No Subject struck with sv	
Division tal or Attendi rs after death.	icat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Nu.	umber or Rural Route Number, City
Div Hospital or 24 hours afte Funeral Dit tely filled in	Certification:	3 Suicide 6 Could not be determined (Specify) Backyard or Town, State) 310 East University Park	way, Baltimore, MD
Di To the Hospital within 24 hours a To the Funeral I completely filled			nner as stated.
To the Ho within 24 t To the Fu	Medical	(critical only)    Critical only   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, at and manner stated.	
7 -3-0	ž		signed (Month, Day, Year)
		anne	ber 15, 2009
		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	210	· ·	
Pogis		THE COUNTY OF A SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND SECOND	

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month September 17, 2009 12:20 PM George M. Swope 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany Dennett Road Manor 0akland | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | May 24, 19 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1**)** M 2 □ F Yrs. 217-14-2979 1922 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Allegany Mount Lake Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1113 Mary Drive #403 21550 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 MYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐Yes 2 No white Specify: 3 ☐ Widowed 4 ☐ Divorced 43-46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 technician elctrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wesley Stephan Swope Carolyn Huges 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Swope/spouse 1113 Mary Drive #403 Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 21. Signatur 1 Funeral Sovice Licensee S. Wade 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown

**Physician** /Medical Examiner

permit. Pages 1
Department of H
Important: If ite
any injury or ot
once.

**Physician** 

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Director

Funeral

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Completed

Be

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MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

"natural",

item 27 is marked other than "natu other traumatic event, the Medical

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

/Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical ģ Completed Be ၉ Certification:

Medical

State Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed 1 □Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural Accident

29b. Signature and title of certifier

Hospital: 28a. Date of Injury (Month, Day, Year) 5 Pending investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 Suicide

4 🗌 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month. Day, Year)

30. Name and address erson who completed cause of death (Item 23a) (Type, Print

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Helen E. Sautter 6:15 А.м 2009 September /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 5119 South Street Baltimore Halethorpe If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 1 F 82 219 20 6181 Director Maryland 02/06/1927 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event. The Marked of the standard or other traumatic event. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐Yes 2 TÃNo Director Baltimore Halethorpe Marvland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5119 South Street 21227 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2½ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Giant Food 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Schumaker (not available) Marv 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Sautter / Son 5119 South Street Halethorpe, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10/01/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 monuella 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequince of): months /Medical Examiner Sequentially list conditions Examiner Dus to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1∠ mon 1∠Yes 2 No 9 Unknown in the past 12 months? 4 Pregnant at time of death Month 5 Other (specify) signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed been 8 Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2. No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Leath Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after deatle Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one. within 2 To the I 29b. Sign 29c. License number ad title of certifie ture 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Ave BALTIMORE MC

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month Charlotte Samuel 2009 Medical 40a4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Future Care Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F (Month, Day, Year) Months Hours Director 97 225-20-7717 Usual Residence of Decedent fshov 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10d. Inside City Limits Director MD NA Baltimore 1 🛚 Yes 2 🗆 No 10e. Street and Number 10g. Citizen of What Country? Funeral 1000 North Gilmor Street 21217 U.S.A. should be filed within 72 hours after death on and Mental Hygiene. I is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔏 No
If Yes, Give 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black 3 Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Provident Hospital 9th_grade na Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mattie Brougdon Elijah King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1531 North Stricker Street, Baltimore, 2Md Page 1 and 2 shment of Health a Edna Cox-Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important; If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/2/09 Arbutus, Arbutus Memorial 21. Signature of Funeral Service Licensee March F/H West Baltimore, Md21215 4300 Wabash Ave, . Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ END-STAGE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ATHEROSCHEROSI CORONAR. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a sunsequence of, burial-transit DEHYDR certificate be executed A7105 and resulting in death) Last Due to (or as a consequence of) attending physician MAZNUTRITION Physician/Medical 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Box Live Birth 2 - Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy that the death ō in the past 12 months? Month Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, ANACMIA cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed's 1 Yes 2 No certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 9 No 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending Division 1 Tes 2 No Accident Investigation Suicide 6 Could not be

Registrar DHMH 17 Rev 7/2009

State

Medical

the Hospital

3 Suicide

only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

KDEY EMISI

29a. Certifier

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

 $m \cdot \diamond$ 

SANTA

32. Rehistrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2600

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D00614

NIBERTY

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HEIGHT

29d. Date signed (Month, Day, Year)

ANCE

21215

BALTIMORE MO

			For State Registrar	State of Maryland Dec	partment of Health and ertificate of Death		iene eg. No.	91151
ı	Physici	an	Decedent's Name (First, Middle, Last)     Ehsan	Mohamed	Sadek	2. Date of Death Month O 9	29 2009	3. Time of Death 1:20p M
-	/Medic Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Deat		4c. County of Deat	h
, phi			9403 Planetree		Owings Mill		Baltin	
1	Funeral Director		5. Social Security Number  N/A  6. Sex	7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		Year) 9. Birt Co	chplace (State or Foreign cuntry) EGYPT
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or I	ocation			10d. Inside City Limits
	Maryla a-f sho ified at	tor	MD Baltin		ings Mills			1 □Yes 2 No
	th with the 23a or 28a ist be noti	Funeral Director	10e. Street and Number 9403 Planetree	Circle Apt 303	10f. Zip Code 21117	10	og. Citizen of What Co Egypt	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm, M. clical Exmitner must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	3. Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes ※☐ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Cauca Specify: A	esion
21215-0036	n 72 ho "natur edical	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Giv	cedent's Usual Occupation we kind of work done during most of wor DO NOT use retired)		16b. Kind of Business/	Industry
212	d withir giene. er than	Somp	lementary/Secondary (0-12) 12th grade	College (1-4or 5+)	Unemployed		Unemp	loyed
nd	be file ital Hy id othe event,	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, M	faiden Surname)	
Maryland	should nd Mer marke imatic	၉	Mohamed Sadek  19a. Informant's Name/Relationship (Type	pe. Print) 19b. Ma	Ismat iling Address (Street and Number or Fi	Nadouri ural Route Number	City or Town, State, 2	Zip Code)
, Ma	and 2 sealth an n 27 is ler trau		Mohamed Said-So		3 Planetree Cir	cle Apt	303, Ow:	21117 ings Mills
ore	iges 1 and the first of He or oth		20a. Method of Disposition  15□ Burial 2 □ Cremation 3 □ R	emoval from State 20b. Place of Dis	position (Name of rematory or other place)	Date 2	20c. Location - City or	Town, State
Baltimore,	mit. Pa bartmer bortant: Injury	1	4 Donation 5 ☐ Other (Specify)  21. Signa ure of uneral Service License		emorial Park 9/ ^{22 Name and Address of Facility} March F/H West	30/09	Woodlawn	n, Md
<u>~</u>	Deg Imp		> somala C	JUNION I	4300 Wabash Ave			21215
	DI		23a. P (1. Enter the disease, or complication) and the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	e cause on each line.		c or respiratory arre	est,	Approximate Interval Between Onset and Death
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	Examiner	<u>.</u>	Sequentially list conditions,					
	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events in the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of th	Due to (or as a consequence or).				
60,	ficate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a consequence of):				
68760,	rtificate ng phys as the	edical	d				3-3,000	
P.O. Box	the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The Law hours after death. This certificate has been signed by the aftending physician and the Euneral Director: After this certificate has been signed by the aftending physician and the Europetey filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown		23d. Date of de Month	livery Day Year	
ds, P.	uires that I signed by Id be deta	þ	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.		pacco use contribute to	o the cause of death?
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/ita	cian: ertifica ector, p	Be C	25. Was case referred to medical examiner?			ath (Check only on		
<del>_</del>	ding Physician: The Ih. After this certificate har funeral director, page		1 Yes 2 No H	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpat 28a. Date of Injury 28b. Time			ence 6 ☐ Other (Spe ow injury occurred	ecify)
on	nding tth. :: After e funer	ation	Patural 5 ☐ Pending investigation	(Month, Day, Year)		28d. Describe no	w injury occurred	
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (St City or Town	reet and Number or R. n, State)	ural Route Number,
-2	Hospita 24 hours Funeral etely fille	Medical C		isician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.				
	To the within To the Compli	Me	29b. Signature and title of certifier	and married deated.	29c. License number	2	9d. Date signed (Mont	th, Day, Year)
			Payny Mills	MO	DA7683	0	9/30/09	
			30. Name and address of person who co		e, Print) Zus Rennestown MD	74/11		
	Sta	te	31. Date filed (Month, Day, Year)	Man Street Sime 32. Begistrar's Signature	w warner war	0036		
	Registr		GCT 0 1 200	9 Duena S. A	harred			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		ary arra / =	Certificate of	Death	F	Reg. No.	
	Physici /Medic		1. Decedent's Name (First, Mide	dle, Last)				2. Date of Dea Month	th Day Year	3. Time of Death
			Howard	Ea	rl	Smit	:h	09	25 200	
~. }	Examir		4a. Facility Name (If not instituti	-		4b. City, Town, o	r Location of Deatl	1	4c. County of De	ath
T			32 South Cat				If Under 24 Hrs.	O Date of Digital	- 0 B	irthulano (Ctata ar Faraign
В	Funeral Director		5. Social Security Number 240–02–0082	6. Sex 7. A(	ge (In yrs. last bir 52	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day 06 12	7, Year) 9. B	irthplace (State or Foreign Country) NC
	w w		Usual Residence of Decedent  10a. State 10b. Count	v	10c. City, Town	or Location				10d. Inside City Limits
	f sho	ō	MD NA		1	ltimore				1 Xves 2 □ No
	the N	rect	10e. Street and Number	-		10f. Zip Code			10g. Citizen of What C	Country?
	with with	Ö		handaa Chu		'	L223		U.S	
	leath	era	32 South Cat	12. Was Decedent				pecify Yes or No-		erican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanuatic rust be nedited at ance.	Completed by Funeral Director	1 Newer Married 2 Ma 3 Widowed 4 Divorce	Armed Forces?	? <b>/</b> No	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No		o Rican, etc.)		
5-0	72 hc	etec	15. Decede	nt's Education est grade completed)	16a.	Decedent's Usual Occup (Give kind of work done		kina	16b. Kind of Busines	s/Industry
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and	be fill	Be	17. Father's Name (First, Middle William H. S					ne (First, Middle, : ne Dick	Maiden Surname)	
Z Z	d Mer narke	은			1					
Maryland	d 2 sh th and th sm 7 is m traum		19a. Informant's Name/Relation  Roy Smith-Br			Mailing Address <i>(Street</i> 601 Alter				•
	1 and Health em 27		20a. Method of Disposition	.Other				Date	20c. Location - City of	
Baltimore,	ages ent of t: If it		1 X Burial 2 ☐ Cremation			Disposition (Name of y, crematory or other place	i i		•	
Ħ	artme ortan injury		4 □ Donation 5 □ Other ( 21. Signature of Funeral Service		Hamı.	lton Garde		/3/09	Wilson,	NC
Ba	permit. Pages 1 Department of H Important: If ite any injury or ot once.		Mumis	JB. The	Le Le	March F/H 4300 Waba	H West Ash Ave			
			23a. Par 1. Enter the Lisease, of shock, or heart ilure. Lis	or complications that constant only one cause on each li	the death. Do r	not enter the mode of dying	g, such as cardia	or respiratory ar	est,	Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition	_a/	$U\Omega U\Omega$	rulal	LAH	UN41	01	Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as	onsequende o	of):	VI X	10		
,	EXCITION 101	<u>.</u>	Sequentially list conditions,	b	$\mathcal{L}$	Or. 41	+ L	NO .		
	ted ssit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o	л,				
	and al-trai	xar	that initiated events resulting in death) Last	C. Due to (or as	a consequence of	of):				
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687	ertificate ling phy e as the	Medical		0.						
Вох	roenti nding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of d	lelivery
-	death ce a attendi d for use	Physician/	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant a	2  Fetal death at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у		Month	Day Year
0	at the de by the tached	hys	9 Unknown	9 ☐ Unknown						
σ, σ.	s that med to e deta	by P	Part II. Other significant condit	ions contributing to death b	out not resulting in	the underlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
of Vital Records,	w requires been sign should be			****				1 □ Y	es 2 □ No 3 □	Probably 4 Onknown
S	aw re is be	Completed						24a. Was a	an 24b. Were	autopsy findings available
ŭ	The lav cate has page 2 :	E						autop:	med? prior to death? 2 1 Ye	o completion of cause of ? es 2 □ No
ita		Be C	25. Was case referred to medic	al			26. Place of Dea	1 □Yes		95 2 1110
f V	di isi	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	ent 2 ER/Ou	tpatient 3 DOA Oth	er: 4 🗆 Nursing H	ome 5 Resid	ence 6 □Other (Sp	pecify)
0 _	ding Pt h. After tt funeral	l:	27. Manper of Death 1 ☑ Natural 5 ☐ Pend	28a. Date of Injury	ury 28b. T	ime of 28c. Injur			ow injury occurred	
Division	Attending r death. ector: After by the funer	Certification:	2 ☐ Accident inves	igation	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Yes 2 □ No			
Ĭ	il or Attend after death Director:	ŧί	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	nined 28e. Place of In building, el	jury - At home, far tc. <i>(Specify)</i>	rm, street, factory, office		28f. Location (S City or Tow	treet and Number or i	Rural Route Number,
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n	e Hospital 24 hours a E Funeral letely filled	Medical	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the best I Examiner: On the basis	of examination an	, death occurred at the ti d/or investigation, in my o	me, date and place opinion, death occu	e, and due to the our corred at the time, o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
2	To the Hosp within 24 ho To the Fune completely f	Mec	29b. Signature and title of certifi	er and manner st	/	29c. Licens	se number	. 2	29d Date signed (Mo	nth, Day, Year) _
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_			30. Name and address of person	who completed cause of c		100014	Him	1805+	MILI	mreMd
	Sta	te	31. Date filed (Month) Pay Yea	1 2009 32. Begisti	rar's Signature	parket			- INCIII	21223

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# 19a, per FH, G896, 1075709, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12.05 AM AZAR -SARHAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Health & Rehabilitation Bethesda Birthplace (State or Foreign Country)
 Syria If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 12/15/ 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 1 **M** M 2 □ F 214-23-4529 76 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examinar must be notified at once. 1 XYes 2 No Director Rockville MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20853 4604 Brad Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Air Space Air Space Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u>Wadiaa Sarhan</u> ဂ Mtanios Sarhan 19a. Informant's Name/Relationship (Type Print)
Antoinette Najmeh/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rockville, MD 20853 Kamil Sarhan / 4604 Brad Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 9/30/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 22. Name and Address of Facility Maryland Cremation Services 21. Signature of Funeral Service Licensee pulle Marshan P.O. Box 1413 Baltimore, MD 21203 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PNEUMONIA Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner TENKEWIL LUMPHOCUTIC CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by MELLITU Threm Boly to PENIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown SINUSTIS PERTHUROLD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 Yes 2 Kiloto CHRONIC DIARRIEN 1 ☐Yes 2 ☐No 1 ∐ Yes Division of Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 17656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEM CHASE ONDUDUNG M.D. 5530 MISHONSIN \$ 550

32. Registrar's Signature

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**ORIGINAL** 

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First Middle Last) Month Day Year **Physician** 2009 Baby Boy Starks 24 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 2 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday) **Funeral** 1 🛣 M 2 🗆 F Months Days Hours Min. infant Sept 24, 2009 Director Maryland Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a State 10b. County 10c. City. Town or Location show items 23a or 28a-f sho ner must be notified at 1 Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 749 Lennox Street 21217 USA Funeral · death v 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify þ black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be April Starks ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 Nother (Specify) in state 21. Signatu of Funeral ervice Licental S. W. 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Chie (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ed by the atten detached for a Month Day in the past 12 months? Pregnant at time of death 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has page 2 No 1 XYes 2 🗌 No 1 Tes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA မ After this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury after death. 1 🗌 Yes the 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 hou

To the Fune

completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier မ

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signature

B. Barks

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600 North Wolfe St, Baltimore, MD, 21287

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 854 AM 2009 WILLIAM ALEXANDER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Housed General Hospital If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 6 Yrs. Min mi 213208990 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in a Maryla Ers. in an injury or other traumatic event, in a Maryla Ers. in a continual be could dead once. 1 ☐ Yes 2 ☐ No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 59260 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 🖼 Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 2 Hanson U150 MU 16 la 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Bald. mD 21239 Nat 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory irrest, shock, or him it failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician myocardial resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 🗆 No 1 TYes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 R/Outpatient 3 DOA this 1 Inpatient Certification: To funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred After 1. Natural 5 Pending investigation I hours after death. uneral Director; A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magney stated. 29a. Certifier

**Division** within 24 hours a

> State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIHALICK

29c. License number

D0050538

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 7 1 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Month Sept 8:02 ₽ M Marv Jo Swain 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Union Memorial Hospital Baltimore n/a 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) Date of Birth (Month, Day **Funeral** 1 □ M 2 🛪 F Days Hours Min. Months Yrs. Director 11/18/33 218-28-7238 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show event, the Medical Examiner must be nytified at Director 1 ☐ Yes 2 No MD Baltimore Halethorpe 10e. Street and Number 10g. Citizen of What Country? ò 23a 3014 Maryland Ave. 21227 USA Funeral or items, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Nidowed 4 Divorced Specify: "natural" White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other 1 any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Joseph Eugene Lucas Dorothy Marie Bowen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Jimmie E. Swain, Jr. / Son Mechanicsville, Md. 20659 39434 Jarrell Dr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 10/2/09 | Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List poly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Distress disease or condition resulting in death) month /Medical Due to (or as a consequence of): Examiner secondy to C spine Stenosis Muscular weakness Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and month status change Mental and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the burial years Physician/Medical Cardiomyopathe chemic IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 2 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 □ npatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT2438946 Sept. 27, 2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital, 201 E. University PLWY, Baltimore, MD ZIZIS Forouhar

State Registrar 31. Date filed (Month, Day, Year)

CT 0 1 2000

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2009 2:45 Sept Evelvn Scardina Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Co. Timonium <u>Stella Maris Hospice Ctr.</u> 9. Birthplace (State or Foreign If Under 1 Year I If Under 24 Hrs. 8, Date of Birth Social Security Number 7. Age (In yrs. last birthday) Date of Disc. (Month, Day, Year) **Funeral** Hours 1 M 2 F Days Min 214-03-2024 Director Sept. Maryland 89 Usual Residence of Decedent 28a-f show 10h. County 10d. Inside City Limits 10a. State 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Tyes 2 No Maryland Baltimore Edgemere ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21219 United States 2825 Lodge Farm Road Apt. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Homemaker</u> <u>Own Home</u> Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Dysu Raphael DiAngelo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3814 Washington Ave. Abingdon, MD Mr. Richard Kordek (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Sacred Ht. of Mary Cem. 9/30/20\$9 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Wise Ave. Dundalk, Maryland and 1. Enter the disease, or complications that caused hock, or heart failure. List only one cause on each line. implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) r as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 1 L Yes 2 No 9 Unknown Pregnant at time of death þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 Probably 4 Unknown 1 Tes completed filled in by the funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 24 hours after death. Funeral Director: After this certificate has perform Hospital or Attending Physician: The 2 🗆 No 1 Tes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence မ ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗍 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred 28b. Time of Certificate: Natural 5 Pending 2 🗌 No 1 Tes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 20b perFH . G896 . 1076 / 09 . WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 Physician 2009 03:55 Stouten /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Manor Care Ruxton Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 □ M 2 🔀 F Months Days 217-24-1874 03/21/1929 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show ns 23a or 28a-f sh Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5900 Sefton Avenue 21214 U.S.A. Funeral 7 is marked other than "natural", or items traumatic event, it e Modical Examinar m 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Hame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Gryzchowiak ဂ Julia Wisniewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Arie B. Stouten, Jr., Husband 5900 Sefton Avenue, Baltimore, MD 21214 permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/02/2009 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Olyanava 8 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Desentin **Physician** year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-transit and Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 💆 No 1 ☐ Yes 2 🕍 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after death. To the Funeral Director; A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier-29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11 Berto 8 OCE . 31. Date filed (Month, Day, Year) OCT 0 1 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 29, Margaret Cecelia Tormollan 2:22 A.M 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🛣 F Months Days Hours Min. 213 34 0596 100 12/21/1908 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a State 1 ☐ Yes 21 No Harford Forest Hill Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 1708 Belvue Drive 21050 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married 1 ☐Yes 2X No Specify White 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 5th Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (not available) Hendricks (not available) Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Tormollan / Daughter in law 210 Somerset Road Stevensville, Maryland 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🖫 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 10/05/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 rt1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) days Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 X No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

event, the Medical

2 should be filed within and Mental Hygiene.

Pages 1

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

29a, Certifier

29b. Signature and title of certifier

INMMD

State Registrar

DHMH 17 Rev 1/2001

and manner stated

116 Harford Road

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

tallston MD

29d. Date signed (Month, Day, Year)

September 29, 2009

Daniel Hanciswest 09-07057 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** yland / Department of Health and Mental 1- For State Certificate of Death 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day September 9, 2009 Medical Examiner 2146 hrs Francis 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2179 Marshall Hall Road **Bryans Road** Charles 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) Director Months oreign Wisconsin Days 452-72-7343 1 XM 2 62 Yrs 05/20/1947 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show s e notified at once. Charles 1 Yes 2 X No Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Bryans Road Directo 10e. Street and Number 10g. Citizen of What Country? 2179 Marshall Hall Road 20616 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces 1 Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 4 Divorced If Yes, Give Year 1970-1972 3 Widowed 1 Yes 2 No specify: 2 Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) item 27 is marked other than "traumatic event, the Medical 4 Choreographer Theater 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) George W. West Marian Dwyer 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George N. West/ Brother 10414 Timbercrest Lane, Austin, Texas 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State September 29. Burial 2 X Cremation 3 Removal from State crematory or other place) Donation 5 Other Specify: Metro Crematory, Inc. Baltimore. Maryland 2009 Signature of Funeral Service Licensee Amanda Heaston | 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 Physician Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line /Medical Between Onset and Smoke Inhalation and Thermal Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): andtransı cian/Medical attending physician or use as the burial -X UNPENDED AMENDED 23a,27,28a-f per me g896 10-19-09 vt Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Day Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: Other₄ Inpatient 2 1 Yes ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✓ Other: Scene No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural Pending 9-9-09 1 Yes 2X No 2130 hrs. Accident Investigation unknown 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2179 Marshall Hall Id. Bryans Rd, Md. 20616 Suicide 6 X Could not be Bryans Rd, determined (Specify) residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 10, 2009 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 1 2009 Registrar escere

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State of Maryland / Department of Health and Mental Hygiene

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	/Medio		Duane Georg						SEPTEM	BOR 28	2001 2300		
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	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location	1				10d. Inside City Limits		
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	To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical L	Examiner: On the basis of and manner sta	f examination and	d/or investig	ation, in my o	pinion, death occur	red at the time, da	ate and place, and d	ue to the cause(s)		
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			30. Name and address of person v	the completed cause of d	leath (Item 23a) (	Type, Print) 5 40	1040	COUNT &	long Ra	indallshw	0M M		
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature						w		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day September 27 Year Williams HIND **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6-14-1977 If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) 6. Sex Social Security Number Months Days Hours MD 1 **X** M 2 □ F **Funeral** 32 212-90-3055 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 10a. State or 28a-f show notified at 1 XYes 2 □ No Director N/A Balto MD 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ō items 23a or ner must be r SA U 21202 Federal Street 340 E. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates Black Pages 1 and 2 should be filed within 72 hours after or the thath and Mental Hygiene. 1 ☐ Yes 2 X No Examiner Never Married 2 Married Baltimore, Maryland 21215-0036 ò þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) "natural" 16b. Kind of Business/Industry Completed 15. Decedent's Education Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed and Mental Hygiene. Unemployed llth grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ansocoee Talbert James Williams, ည or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto, MD 21202 340 E. Federal Street permit. Pages 1 and 2: Department of Health at Important; If item 27 is any injury or other trau Ansocee Talbert-Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Trinity Cemetery 10-3-2009 Balto, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licenses 1101 E. North Avenue Balto, 21202 lader an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Idisease or condition resulting in death) **Physician** Due to (or as a consequence of) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the as 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy use 23b. Was decedent pregnant Year 3 Ectopic pregnancy Day 2 Fetal death Live birth in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) detached for Pregnant at time of death 2 🗌 No 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed by 3 ☐ Probably 4 ☐ Unknown ğ 1 Tes 2X No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 2 🗌 No 3 1 TYes certificate 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director; After this certifical completely filled in by the funeral director; 25. Was case referred to medical Be Other: examiner? 6 Other (Specify) Hospital: 4 Nursing Home 5 Residence 2 X ER/Outpatient 3 □ DOA 1 ☐ Yes 2 No 1 Inpatient ၉ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 27. Manner of Death Certification: Injury 5 Pending investigation Natural Accident 1 🗌 Yes 2 🗌 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 4 Homicide ō Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760,

Hospital the

State

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Keza

600 North Wolfe St, Baltimore, MD, 21287

31. Date filed (Month, Day, Year) Registrar

one)

29b. Signature and title of certifie

Medical

32. Registrar's Signature

		4	_ State	te of Maryland / Depa Cea	artment of H			епе eg. No. ( — [ ] ( )	0.1122
			Registrar  1. Decedent's Name (First, Middle, Last)	<del></del>			2. Date of Death	) and the gar	3. Time of Death
PI	hysicia Medic		Gladys Juel Wall				Sept. 2	28, 2009 Year	11:52A.™
E	Examin	er	4a. Facility Name (if not institution, give street and		4b. City, Town, or I			4c. County of Death	h
Fı	uneral		Bluepoint Nursing  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9, Birt	hplace (State or Foreign
	rector		216-30-0259 1 □ M 2x	74 Yrs.	Months Days	Hours Min.	(Month, Day,	1935 N	.Carolina
pu	show	h	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
Maryla	28a-f ;	rect	Maryland N/A	Baltin	nore		<u></u>		1 Yes 2 No
th the	3a or 2 t be no	Funeral Director	10e. Street and Number 2837 Waldorf Avenu	10	10f. Zip Code 21215		1	0g. Citizen of What Co USA	untry?
ath wi	ems 2	uner		Decedent Ever in U.S. 13.1	Was Decedent of His	spanic Origin? (Spec	cify Yes or No-	14. Race - Ame	rican Indian,
<b>3-0030</b> 2 hours after de	ral", or ite Examine	by	1 Never Married 2 Married 1 If Ye	ed Forces?	If Yes, specify Cuban  1 ☐ Yes 2X No		Rican, etc.)	Black, White	
<b>2</b> -0	"natu edical	Completed	15. Decedent's Education (Specify only highest grade comp	leted)   (Give	dent's Usual Occupa kind of work done du	tion uring most of workin	g	16b. Kind of Business	Industry
ithin 7	r than the M	Con	Elementary/Seconday (0-12) Colle 11th grade	ege (1-4 or 5+) (ife. D	O NOT use retired)		l I	Private I	ndustries
filed w	d other	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	aiden Surname)	
Maryiand 2 should be filed th and Mental Hy	narke	잍	Miles Cannon			Gladys			
, Mai od 2 sho salth and	n 27 is r er traun		19a. Informant's Name/Relationship (Type, Print) Mavis Anderson/ Nie	ece 103 I	ng Address (Street ar N.Rock G	len Rd A	Apt.C I	City or Town, State, Zip Baltimore	Maryland
<b>Saltimore,</b> permit. Page 1 and Department of Hea	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo	osition (Name of matory or other place n Forest	! D	ate 1	20c. Location - City or Dwings Mi	Town, State
balt permit. Departr	Import any inj once		21. Signature of Funeral Source Pensee	52		terstown	n Rd Ba	altimore,	neralHome MD 21215
			23a. Part 1. Enter the disease, or complications shock, or beart failure. List only one cause	that caused the death. Do not ent on each line.	er the mode of dying	, such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death
	sician/ edical	1	Immediate Cause (Final disease or condition resulting in death)	ue to (or as a consequence of):	nal tout	vie			Glidet and Beam
	miner				untlatio	j			
-	±	iner	cause. Enter Underlying	ue to (or as a consequence of).				- 3	
executed	and I-trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	ue to (or as a consequence of):					
ate be ex	physician and the burial-transit	edical	d						
8/0 tificate	ng phy as the		IF FEMALE:						
DIVISION OT VITAL RECORDS, P.O. BOX 08/00 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.	the attendi hed for use	Physician/M	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)	у		23d. Date of de Month	livery Day Year
that the	e detac	by Ph	Part II. Other significant conditions contributing	g to death but not resulting in the i	underlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
<b>ds,</b> quires	en sig ould b	ted	Denenta:				1 □ Y€	^	robably 4 🗌 Unknown
DIVISION OT VITAI RECORDS, tal or Attending Physician: The law requires rs after death.	has be e 2 sh	Completed	DVT				24a. Was ar autops perforr	y prior to	topsy findings available completion of cause of
n: The	fficate or, pag		25. Was case referred to medical		26 Pla	ace of Death (Check	1 Yes 2	No 1 🗆 Yes	s 2 No
VITA Iysicia	is cert direct	To Be	examiner? 1  Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpatie	Othe	r /		nce 6 Other (Spec	ify)
ing Ph	offer th		27. Manger of Death 28a.  1 Natural 5 Pending	Date of injury (Month, Day, Year) 28b. Time of injury	work	?	8d. Describe ho	w injury occurred	
SION vttendi death	ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	Place of Injury - At home, farm, str		Yes 2 ☐ No	28f. Location (Str	reet and Number or Ru	ral Route Number,
JVIII alor A safter	Il Dire		4 Homicide determined	building, etc. (Specify)	,,		City or Town		
Hospit 24 hour	Funers	Medical	29a. Certifier (Check 2 Medical Examiner: On t	the best of my knowledge, death he basis of examination and/or inves	occured at the time, stigation, in my opinio	date and place, and n, death occurred at	d due to the caus the time, date an	se(s) and manner as sta d place, and due to the	ated. cause(s) and manner stated.
To the	<b>To the</b> comple	Σ	only one) 3 ☐ Certifying Nurse Practi 29b. Signature and title of pertifier	oner: To the best of my knowledge,	29c. License			9d. Date signed (Monti	
			· hhrmo		HO	0ie4267		9-30-	09
	7		30. Name and address of person who complete	posin 5- Braces	Print) B27 Ur	iden HV	· Balt	MO 2120	7
F	Sta Registra		31. Date filed (Month, Day, Year)  OCT 0 1 2009	32. Registrar's Signature	20				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 2:37 PM **Physician** Ellen Willing 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, Y)
June 17, If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year unk 1 □ M 2 👿 F 63 1946 Director 220-70-0034 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County 28a-f show ed other than "natural", or items 23a or 28a-f shov event, the Modical Experient is ust be notified at Yes 2□No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 USA 2700 N. Charles Street Funeral hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔏 No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🕅 No Specify: If Yes, Give Year or Dates: Specify: white þ 3 Widowed 4 Divorced Completed 1111 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other event injury or other e College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Union Memorial Hospital 201 E. University Parkway Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 NOther (Specify) in state Ronald S. Wade 22. Name and Address of Facility 21. Signature Director State Anatomy Board Baltimore, MD 2120 655 W. Baltimore Street Baltimore, 23a. Part 1. Enter the disease, or/complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or-heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): 445 /Medical Examiner Chronic respiratory failure JEars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical as the l IF FEMALE for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown retardation cate has been si page 2 should t wental Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 ☐ Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 🗌 Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 09,23,2009 flowsice, MD

State Registrar 31. Date filed (Month, Day, Year)

OCT

DHMH 17 Rev 1/2001

Dark

Hallowsky Apunion memorial Hospital; 201 E. University Parkuray, Baltimore, MO 21218.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 7, SperFH, G896, 10/6/09, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decede Name (First, Middle, Last, 2009 Sept. Physician 10:30 A M /Medical City, Town, or Location of Death 4a. Facility Name (If not institution, give street and nun 4c. County of Death Examiner :11ows atonsville Baltimore 8. Date of Birth 1927 Dec Year If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral-1**X**M 2□ F 82 Min. Months Days Hours - 81^{Yrs.} Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. Count permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner result be reaffied at once. 10a. State 1 ☐ Yes 2 No Be Completed by Funeral Director atonsuille timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USF 21228 llows 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XXNo Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Covege (1-4or 5+) Elementary/Secondary (0-12) sovernmen Norker Tvrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည nannie Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) Grace Walker Catonsville, MD 21228 Date 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) wings Mills, and 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Deport weeks /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached in 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Medical Certification: To Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has I funeral director, page 2 s 1 ☐ Yes 2 XNo 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: completely filled in by the f 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a, Certifier 1🔁 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of centifier

State

dance

Lance

Gowal

32. Registrar's

address of person who completed cause of death (Item 23a) (Type, Print)

005194

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 12:45 PM 2009 JACQUELINE 25 WHITE SEPTEMBER 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CENTER RALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 166 - 07 - 1968 7. Age (In yrs. last birthday) Days Hours 1 M 2 F

ö or items 23a Maryland 21215-0036 "natural" filed within I Hygiene. than Baltimore,

**Physician** 

/Medical

Examiner JOHNS HOPKINS BAYVIEW MEDICAL 9. Birthplace (State or Foreign Social Security Number **Funeral** 212-11-5106 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10a, State 10h County 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 1 Mes 2 □ No Director tomore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA Nedgewood Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married 1 ∐Yes 2 X If Yes, Give Year or Dates: 2 **X**No 1 ☐ Yes 2 XNo Specify. Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b, Kind of Business/Industry College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event ath Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Numbe City or Town, State, Zip Code) 1107 Place of Disposition emetery, crematory Method of Disposition 1 Surial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ture of Funera Service Licensee 21. Sign 23a. Part1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DAYS RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner WEEKS PNEUMONIA Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the as IF FEMALE: for use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9 Unknown 9 Unknown signed by 1 I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has nerforme page certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 ▼ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deatle Funeral Director; the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the ! within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 SEPTEMBER 25, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar CHANG

M.D

4940

EASTERN

BALTIMORE, MD 21224

### 09-07577 Donald Willey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. For State 3. Time of Death. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1934 hrs September 28, 2009 DONALD LEE WILLEY Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A **Baltimore** 1627 East Patapsco Street 8. Date of Birth (MM/DD/YYYY) g. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Foreign **Funeral** Hours Min Davs 218-42-3408 Months Country) Nov 29, 1946 Director 62 1X M 2 F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County ì 1 X Yes 2 No Baltimore s 23a or 28a-f show e notified at once. N/A Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21230 1627 Patapsco Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. or items. White, etc Armed Forces? Never Married 2 Married 2 x No Yes White Specify Yes 2 X No specify: Yes, Give Yea 4 X Divorced If item 27 is marked other than "natural", her traumatic event, the Medical Examiner Widowed ş 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Chemical Company 0 Baltimore, MD 21215-0036 12 Maintenance 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary P. Smith Gilbert C. Willey, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) (Sister) Joyce P. Dorsey 435 Shady Lane, Pasadena, Md. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 9/30/09 Baltimore, Maryland Bayview Crematory, Inc. Donation 5 Other Specify 9 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kevin E Ecker 3204 Mountain Rd., Pasadena, Md. Approximate Interval 26a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease tamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last pur Physician/Medical AMENDED UNPENDED signed by the attending physician be detached for use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 ✔ No 3 Probably 4 Unknown þ Diabetes Mellitus Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? has performed? 2 No 1 🗸 Yes Yes 2 certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Division of Vital Be Other: Residence 6 🗸 Other: Scene examiner? Hospital: 1 Nursing Home 5 DOA ER/Outpatient 3 Inpatient 2 After this 1 V Yes ဠ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending Director: Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 3 Suicide determined the Hospital Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical within 2and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 29, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD

State Registra

31. Date filed

32. Registrar's Sigrature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Physician/ Sept. 30, 5:00 AM Zellhofer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium 1 Brooking Ct. Unit 101 Social Security Number If Under 1 Year If Under 24 Hrs. Date of b. (Month, Day, Yea 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) 1 M 2 L Months Days Hours Director 81 Sept. 218-26-8450 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🛶 No MD Baltimore Timorium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Brooking Ct. #101 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian Was Decedent 2. Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. q 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) 12 Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph S. May Sophia Wills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles J. Zellhofer/husband 1 Brooking Ct. #101, Timonium, MD 21093 20a. Method of Disposition
1 X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 4 Donation 5 Other (Specify) Moreland Memorial Park 10/3/09 Parkville, MD 21. Signature of Funeral Service Insee ²² Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Inc. Michael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) fati Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Due to (or se a consequence of Cause (Disease or linjury physician and s the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregry 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacab use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s Jas autopsy performed' death? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to make ca Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Schrader, M.D.

29b. Signature and title of certifier

Dr. Richard

32. Redistrar's Signature

7501 Osler Dr. Suite 102

-30-2004

Towson, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Norman Ayres, Sr. 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1116 hrs September 11, 2009 Medical Examiner Norman Ayres, Sr. c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death US Route 113 and Public Landing Road Snow Hill Worcester 1 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director Aug 4, 1941 Country)MD 215-38-0756 68 1 X M 2 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 No 28a-f show Worcester Snow Hill MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoinjury or other traumatic event, the Medic 1 Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21863 USA 6747 McCabes Corner Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married 2 X Married African-Yes If Yes, Give Yaar 3 Widowed 4 Divorced Yes 2 X No specify: Specify. American þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Agriculture 8th Repairman/Farmer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Harmon John Ayres 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6747 McCabes Corner Rd., Snow Hill, MD 21863 Emily M. Ayres/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State St.James AME Church Cem 9/19/09 Snow Hill, MD Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lewis N. Watson Funeral Home, PA 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Head and neck injuries Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ned by the attending physician and detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>á</u> 1 Yes 2 V No 3 Probably 4 Unknown Completed certificate has been ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' Yes 2 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other₄ Nursing Home 5 Residence 6 V Other: Scene this Inpatient 2 ER/Outpatient 3 DOA 1 V Yes No 28a. Date of Injury (Month, Day, Yaar) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Driver auto auto collision FOUND: Natural Yes 2 V No Pending To the Funeral Director: completely filled in by the Sep 11, 2009 1108 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State)
Us Route 113 and Public Landing determined , Snow Hill, Md (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E September 12, 2009 wane TMB Will

Registrar DHMH 17 Rev 1/2001 OCME 2006

State

racks

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

2009

Margarita Korell MD. 31. Date filed (Month, Day, Year) Assistant Medical Examiner

32. Registrar's Signature

1. Decedent's Name (First, Middle, Last)

Physician

2009 Trina LaShan Lockwood Ames SEPT /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death . Examiner HICOMICO REGIONAL MEDICAL MINS4LA 8. Date of Birth (Month, Day, Year)
Dec 23, 19 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs/ 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 🖫 F Director 217-90-6148 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Exacting an unit to a colling a 1 Yes 2 □ No Director MD Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 425 Jefferson St. 21801 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 X No African-Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify. 2 Specify: 3 Widowed 4 Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Eyewear 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Foreman Lockwood, Jr. Diane Carter 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marvin K. Ames/husband 425 Jefferson St., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Acres 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/19/09 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 9/19/09 Salisbury
22. Name and Address of Facility
Lewis N. Watson Funeral Home, PA
1618 West Rd., Salisbury, MD 21801 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sicille Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Lumania. To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 1 TYes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) PAMC 100 E. Carroll 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nati 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Month

3. Time of Death

ee.	Turner	Blades,	Sr.

Please	Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
	State of Maryland / Department of He	ealth and Mental Hydiene

ee Turner Blad	es,	Sr. S 1- For State Registrar	itate of Maryland		artment of			Menta	al Hyg		k.		9 3147
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Funeral Director		5. Social Security Number <b>220–34–7695</b>	6. Sex 7. As		78 Yrs.	If Under Months		If Under		. Date of Bir 1/10/		Forei	rthplace (State or gn puntry <b>MARYLAND</b>
daryland 28a-f show any 1 at once.	_	Usual Residence of Decedent  10a. State  10b. County  MD  CARO			, Town or Locatio	'n	-						10d. Inside City Limits 1 Yes 2 No
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Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Un	he 23c. If yes, outcor  1 Live birth 4 Pregnant at g Unknown		2 Fetal	death r (Specif)	-	Ectopic pr	regnancy		23d. Date o		y Day Year
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Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been s led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director.	Certification:	3 Suicide 6 Coul	stigation    Sep 4, 2009   Sep 4, 2009	ear)	1229 hrs		Yes	2 🗸 No	Driv	ver auto a	auto collisio	n	ral Route Number, City
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: completely filled in by the fi	Medical Cer	29a. Certifier (Check only 1 Certifying P	hysician: To the best of my miner:On the basis of exam	/ knowledg	ge, death occurre	d at the tin	ne, date a	and place,	, and due	to the cause	Road and Co e(s) and manne	r as state	Road, Easton, MD ed. e cause(s)
TLS	Mec	29b. Signature and title of certifie	and manner stated.	fu		29c. L	icense ni	umber			29d. Date sign	ned (Moi	nth, Day, Year)
15		30. Name and address of verson Margarita Korell MD.	Assistant Medical	Examin	er 111 Per		t, Balti	more, N	ИD 212	J 01			
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Registrar

State

Glenn R. Edgecombe

SEP

182009

31. Date filed (Month, Day, Year)

32 Registrar's Signatur

 $^{
m V}$ 11711 Livingston Road, Fort Washington, MD 20794

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 0735 A.M prembo Jesse -in wood 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HICUMICO If Under 1 Year | If Under 24 H/s. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Days 1 **№** M 2 🗆 F 213-22-9915 Feb. 28, 1930 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 □ No Crisfield Director Somerset Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21817 U.S.A. Maryland 220 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give 3 1 15 1 -Year or Dates: ★ 4/115 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 2 3 Widowed 4 Divorced to 4/1154 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Byrd's Sacifood Wor Ker 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willis Sarah Drummond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Crisfield, md 21817 Byrd 220 Maryland Ave tlnora 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Md. Veterans Cemetery 9/21/09 Hurlock, md. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Anthony E Ward F. H. 21. Signatur of Funeral Service Licensee Anthr Cove 010 Wand 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
g ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐Yes 2 ☐ No g | Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes a ☐No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ⊟Yes 2 ∏ No 2 ER/Outpatient 3 DOA 1 Denpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann f Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Latural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Examiner Physician: The law requires that the death certificate be executed attending physician a for use as the burial Box 68760 signed by the a d be detached f o ٣. Division of Vital Records, cate has page 2 s certificate this After Hospital or Attending death. Director: within 24 hours after To the Funeral Direct

**Funeral** 

**Director** 

iral", or items 23a or 28a-f show

traumatic event, the Wedical

Department of Health ar Important: If item 27 is any injury or other traus

**Physician** 

/Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

3+

Registrar

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

614 32. Registrar's Signature

and manner stated.

Box 68760. P.0. Records, Division of Vital

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Lilian Sinclair Burton 09 13 2009 14:33 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HICKMICO TENN SULA BegioNal CENTU 54/156414 MENERL If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 176-28-8215 Days 1 □ M 2 🔀 F 79 05/07/1930 **Director** Scotland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits , or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 1XYes 2∏No Director Wicomico Salisbury Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21801 USA 506 W. College Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐Yes 2 No þ Specify. white 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Librarian education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sinclair Hugh Dickson Anne ပ ab. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
506 W. College Ave., Salisbury, MD 21801 19a. Informant's Name/Relationship (Type. Print) Oswald J. Burton/spouse 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 9/16/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home Professional Association ice Licensee 24. CFSP 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CLASTRY INTESTINA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical attending p If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) I∐Yes 2 No ed by the 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed HYPERTENSUN 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 D 24a Was an autopsy perform 2 Nio 1 □Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examinor? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) 614 SEP 32. Registrar's Signature 31. Date file State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1	State of Maryland		rtment of H		_	giene Reg. No.	119	31473
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/Medica		4a. Facility Name (If not institution, give street and number)	er	4h City Town or	Location of Death				3:34 P
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		St. Thomas Moor Nursing Hom 5. Social Security Number   6. Sex   7. Age (In yrs. la		If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	in I	9. Birtho	lace (State or Foreign
Funeral Director	- 1	579-76-3148 1\(\overline{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\tint{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\tint{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\tinit}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\tex{\tex	Yrs.	Months Days	Hours Min.	(Month, Da May 16	y, Year)	Cour	DC
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once.		21. Signature of Funeral Service Licensee	1/1/	Name and Addre			Funeral :		, Inc.
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25		30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)	A.	1 Hin	Hen	12 1	14,2009 ND2078
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Arlington
National Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o September 1 Burial 2 ☐ Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21, 2009 Arlington, Virginia 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sig of Funeral Salvice Licens 4001 Benning Rd. NE Washington, DC Approximate Interval Between Onset and Death 23a. Part J Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Cardromyopathy Sequentially list conditions Examiner Coast of the way a montagonage of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? 1 □ Yes 2 🖺 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 Tes 2 ANo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division of Vital Records, P.O. Box 68760, hours after death thin 24 hours a Hospital completely

State Registrar (Check only

29b. Signature and title of certifier

SURVIVI

Laura L. Sessums, JD, MD, FACP 6900 Georgia Ave. NW 31. Date filed (Month, Day, 92. Registrar's Signature SEP 2 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

MD31449

29d. Date signed (Month, Day, Year)

09/17/09

WDC 20307-5001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPT.13,2009 **Physician** 8:05 AM CARL FREDERICK BAUERSFELD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL LUTHERAN HOME ROCKVILLE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□F 212-124-803 93 Director JUNE 9,1916 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location or than "natural", or items 23a or 28e-f show The Medical Examiner must be notified at MONTGOMERY ROCKVILLE X Yes 2 No MD. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9701 VEIRS DRIVE 20850 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritaf Status a filed within 72 hours after de l'Hygiene. Other than "natural", or item 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates V W ∏ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE ρ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ATTORNEY AT LAW LEGAL marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be h and Mental I EMIL G. BAUERSFELD IRENE HULSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: if item 27 ie eny injury or other trau once. CARL BAUERSFELD, JR. - SON 634 AZALEA DRIVE, ROCKVILLE, MD. 20850 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date unk. 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON NAT.CEM. ARLINGTON, VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lines see 22. Name and Address of Facility 2222-WISCONSIN AVE., NW HYSONG CO. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final mony **Physician** Accidents disease or condition resulting in death) erebrovascular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed -transit Chronic and resulting in death) Last Due to (or as a consequence of): physician a is the burial-Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ a remia 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 Yes 2 No : After this certifical funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 Inpatient 2 EP/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Natural death 1 ☐ Yes 2 ☐ No after death | Director: / d in by the f 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled within 24 hours a To the Funerel [ Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO050612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9701 Veirs Drive Rockville markano 20850 G. MAIIER MD SAMUEL 32. Registrar State Registrar

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JOU	glas Edward		rns, Jr. State	e or warylan		tificate of		ivientai		201	19 1143
		F	tegistrar  1. Decedent's Name (First, Middle,	l not\		ilicate of	Death		2. Date of Death	J. No.	3. Time of Death
Mad	Physicia dical Examin	1177			-				Month September		1910 hrs
/	ulcai Examii		Douglas Edwar 4a. Facility Name (if not institution,	give street and num	er)		b. City, Town, or L	ocation of D		4c. County of Dea	ath
4			Carroll Hospital Center		,		Westminster	r		Carroll	
	Funeral	-	5. Social Security Number 6	. Sex 7	Age (In yrs. la	st birthday)	If Under 1 Year		4Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. E	Birthplace (State or eign
	Director		219-29-7104	1 XM 2 F	22	Yrs	Months Days	Hours	Min. Sept 1	,	Country) MD
		}	Usual Residence of Decedent						DCDC .	±50 k	
	any	ı	10a. State 10b. County		10c. City,	Town or Locati	on	_			10d. Inside City Limits
	<b>1</b>	_	MD Car	roll	1	Caneyto	wn				1 Yes 2 No
9	r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	ountry?
W.	the Na or	ᡖ	2837 E. Mayberr	y Road			217	87		USA	
	ms 23	era	11. Marital Status	12. Was Dece		S. 13. Wa	s Decedent of His es, specify Cuban	panic Origin? . Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. Race - Am White, etc	erican Indian, Black,
0	death or ite	Ě	1 X Never Married 2 Mar	1 Yes	2 X No					Sanaife	White
M.	after	畜		ced If Yes, Give Year or Dates:			Yes 2 X No		d of work done	Specify: 16b. Kind of Busines	
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	With giene giene ther t	Completed	17. Father's Name (First, Middle, I	ast)	-	20	TTIKTEL .	18.Mother's N	Name (First, Middle, N		
	e filec al Hy ced of	Be C	Douglas E. Co	·				Val	erie Kleir	1	a mean mean
	212 Meni Meni mari	0	19a. Informant's Name/Relationsh	ip (Type, Print )		19b. Mailin	g Address (Stree	t and Numbe	er or Rural Route Num	ber, City or Town, St	ate, Zip Code)
	MD 2 sho 2 sho 27 is		M/M Douglas Col	lins, Sr		2837	E. Mayb	erry R		ytown, MD	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	1	20a. Method of Disposition	O Description		Place of Disposorematory or of	sition (Name of cer ther place)	metery,	Date	20c. Location - City	or Town, State
	nor ages ent of nt: If	- 8	1 X Burial 2 Cremation 4 Donation 5 Other Spe		II State	-	's Cemet	ery 9	/26/2009	Silver F	Run, MD
	altir mit. I porta ury o		21. Signature of Funeral Service 1	icansee		22	Name and Address	of Facility	Home and (	Chapel P.	Α.
	II. II. G. B. W		23a. Part I. Enter the disease, or o	meto		4	12 Washi	ngton	Road West	minster.	MD 21157
	Physician		23a. Part I. Enter the disease, or of failure. List only one cause of	complications that ca	used the death	. Do not enter	the mode of dying,	such as card	iac or respiratory arre	est, shock, or heart	Detricon Onoot and
	taminer		Immediate Cause (Final disease		ations	of mor	phine an	d alco	hol intox	ication	Death
•	tallille		or condition resulting in death)	Due to (or as a	consequence o	f):					
		<u>.</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequence o	of):					
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	6 be e ysicia	ledi	IF FEMALE:	23c If yes 0	utcome of preg	28a-i,p	erME, g8	198 12/	/10/09 TT	23d. Date of deli	very
	Sox 68760, leath certificate be eattending physicia for use as the buria	Physician/Med	23b. Was decedent pregnant in the				etal death 3.	Ectopic p	pregnancy	Month	Day Year
	Sox 6 leath cer e attendi for use	icia	past 12 months?	····· 1 "  = "	ant at time of de	eath 5 C	ther (Specify)				
	Bo le dea the a ted fo	hys	1 Yes 2 No 9 Unk	5 OTIKITO		andina in the	underlying pauce	aiven in Part	23e Did to	obacco use contribut	e to the cause of death?
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	cords, law requir has been s	bet							autor		to completion of cause of
	<b>Recc</b> The lar cate ha	Completed							1 ✔ Yes		Yes 2 No
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	sior ttend death ctor: y the	ĕ		tigation 9/19/		0416 ł	ırs		unk	(Street and Number of	or Rural Route Number, City
	Divisi pital or Ati ours after d	ertification:	3 Suicide 6 X Coul	not be			eet, factory, office	building, etc.	or Town,	State)	
	Division of Vital Records, P.O. Box 68760, To the Itopital or Attending Physician: The law requires that the death certificate be Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	၂ ပ	4 Homicide	1 -477		r -resi		date and sic-			Taneytown, MD
	To the Hos within 24 h To the Fur completely	ical	(Check only one) 2 Medical Example 1	nysician: To the bes miner: On the basis of	t of my knowle of examination	uge, death occ and/or investig	ation, in my opinio	n, death occ	ce, and due to the cau urred at the time, date	e and place, and due	to the cause(s)
d	To t with To t	Medical	29b. Signature and title of certifie	and manner s				nse number			(Month, Day, Year)
		=	Mani	//_		MP	0.0	.M.E.		September 2	2, 2009
			30. Name and address of person	who completed	e of death (Ito	m 23a\					
	المراد		30. Name and address of person Russell Alexander MD				1 Penn Stree	t, Baltimoi	re, MD 21201		
	₩ 	tate	31. Date filed (Month, Day, Year)	32. Re	egistrar's Signa	ture					
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						-			3.00.30	True	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician John Ε. Council entember 200' /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Plata La If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year)
11-26-20 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Min. Hours **XXX** 2 □ F Months Days 88 Director 229-18-4608 Va. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important; or items 23a or 28a-f shoi Important; If item 27 is marked other than "natural", or items 23a or 28a-f shoi any Injury or other traumatic event, the Medical Exp. niner must be notified at Director 1 Yes 2 □ No Charles Waldorf MD. 10e Street and Number 10f Zin Code 10g, Citizen of What Country? 20602 U.S.A. 410 Garner Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Armed Forest.

1 XYes 2 No
If Yes, Give 11/21/4Z
Year or Dates: 11/21/44 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Black Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) G.S.A. Carpenter 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ophelia Robinson ပ John F. Council 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellis/Sister 105 Orange Dr. Williamsburg, Va. 23185 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cem. 9/24/09 Brentwood, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hackett's Funeral Chapel,
814- Upshur Street, N.W. 21. Signature of Funeral Service Licenses 20011 Hrt 1. Et er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a Examiner equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 100 1 ☐ Yes 2 ☐ No 1 □Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Ye,s 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Many r of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number AV. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ON 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Madelyn Marie 8:50 a Chrisman September 16, 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Silver Spring 815 Philadelphia Avenue Montgomery 8. Date of Birth (Month, Day, Year, Dec. 8, 1 If Under 1 Year | If Under 24 Hrs 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. New Hampshire 1 □ M 2 F 052-26-5333 77 1931 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Montgomery Silver Spring 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò death with 23a 815 Philadelphia Avenue 20910 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian Black, White, etc. 72 hours after ∐Yes 2 🔀 No 1 Never Married 2K Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No White Specify þ Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Religious Information than Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed with and Mental Hygier
7 is marked other th Receptionist Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Parker Shannon Ellen Marie McCarthy ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health s Paul V. Chrisman/Husband 815 Philadelphia Avenue, Silver Spring, MD 20910 permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licensee Name and Address of Facility
rancis J. Collins Funeral Home Inc 500 University Blvd. W, . Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 10 years Immediate Cause (Final Physician Cardiac Dysrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Osteogenic Sarcoma 5 years Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consection of off certificate be executed Exami burial-trans Chronic Obstructive Lung Disease 20 years and Due to (or as a consequence of): physician at the burial Box 68760, Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö the 9 Unknown þ σ. signed to be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? aw 24a. Was an page 2 autopsy performed certificate 1 □Yes 2 X No 2 🗆 No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**X** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 29a, Certifier 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43496 Sept. 16, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12001 Ferrara Drive, Wheaton, MD 20906 Mohammed Khalid, Md

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

18 2009

32. Registrar's Signature

			1 - State of Maryl Registrar		triment of F tificate of		, ,	ene g. No./	3 4 3 4
	Dhusisi		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Aicha Chen					r_9, 2009	7:35 AM
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Deat	th
· grand			Holy Cross Hospital		Silver			Montgomer	J
	Funeral		1 D M 257 E	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	thplace (State or Foreign ountry)
ļ.	Director		Usual Residence of Decedent	83 Yrs.			March 20	, 1926 Ch	ina
	and			. City, Town or Loc	cation				10d. Inside City Limits
	Mary f sh	호	Maryland Montgomery Si	lver Spr	ina				1XYes 2 No
	28a	Director	10e. Street and Number	TAGE PAI	10f. Zip Code		10	g. Citizen of What Co	ountry?
	3a or		1801 Middlevale Terrace		20906				,
	ms 2	Funeral	11. Marital Status 12. Was Decedent Ever i	n U.S. 13. V		lispanic Origin? (Sp an, Mexican, Puerto		Inited Sta	erican Indian,
9	after or ite		Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No				Rican, etc.)	Black, White	e, etc.
93	be filed within 72 hours after death with the Maryland that Hygiene.  dother than "natural", or items 23a or 28a-f show event, the Modical Eventral must be refitted at	d by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	500-01-03	∐Yes 2XX No	Specify:		Specify: As	sian
21215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occup	during most of work	ina 1	6b. Kind of Business/	Industry
2	rithin ne. <b>han</b> "	ld m	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	DO NOT use retire	d)			
7	led w fygie her tl	ខិ	AT 5 II A A A A A A A A A A A A A A A A A	4 House	keeper			House keer	oing
anc	ev d tal	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma	aiden Surname)	
ž	l 2 should be f h and Mental I 7 is marked of iraumatic eve	2	Unobtainable			Unobtain			
Maryland	12 sho th and 7 is ma trauma		19a. Informant's Name/Relationship (Type. Print)					City or Town, State, 2	, ,
	s 1 and 2 should I of Health and Men item 27 is marke other traumatic		Daniel Lin/Personal Rep.					r Spring, Oc. Location - City or	
Baltimore,	Pages nent of int: If its iry or o			b. Place of Dispos cemetery, crem				_	
를	iit. Partme intme intant injury			t. Linco	In Cremai	tory 9/21	/2009   B	rentwood,	Maryland
Ba	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee			ess of Facility Sim			0.50
			23a. Part 1. Enter the disease or complications that caused the d					11e, MD 20	Approximate
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	DO HOLOHO	or the mode of dyn	rg, odori do cardido	or respiratory arres	, , , , , , , , , , , , , , , , , , ,	Interval Between Onset and Death
	Physician /Medical		disease or condition a.Acute myoca		farction				_2_days
	Examiner		Due to (or as a con		. 1 2	1 1 .			Years
b	THE R	ē	Sequentially list conditions, if any, leading to immediate		alovascu	iar disea	ise		rears
2	uted d ansit	Examiner	riany, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events	,					
י כ	execan an an ial-tr	Exa	resulting in death) Last Due to (or as a con-	sequence of):					
68760,	tificate be executed g physician and as the burial-transit	edical	d					_	
			IE EEMALE.					1	
X P	death cert e attending d for use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the post 12 months?  23c. If yes, outcome of pre		l Ectopic pregnanc	V		23d. Date of del	,
	ed fo	sici	1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at time		Other (specify)	,		Month	Day Year
J.	w requires that the d been signed by the should be detached	Physician/M	9 Li Unknown						
Š,	requires that een signed b nould be deta	by	Part II. Other significant conditions contributing to death but not Sepsis, UTI, HTN, hyperlipide:					cco use contribute to	
Records,	requ bould	Completed		mia, all	Tal IIDI.	IIIation,	I 🗆 tes	2 Kg NO 3 L FI	robably 4 🗍 Unknown
ě	2 8 2	nple	hyperkalemia				24a. Was an autopsy	prior to o	topsy findings available completion of cause of
	The licate har, page	ខិ					performe 1 Tes 2		2 🗆 No
VITa	Physician; this certific	Be	25. Was case referred to medical examiner?  1		Oth		h (Check only one)	<u> </u>	<del> </del>
0	그 일 교	<u>٩</u>	1 ☐ Yes 2 ☒ No	2 ER/Outpatient	1 3 1 DOA	4 LI Nursing Ho		ce 6 ☐ Other (Spe	cify)
0	ding h. Afte fune	tion	1 ⊠ Natural 5 □ Pending (Month, Day, Year 2 □ Accident investigation	r) Injury	28c. Injur Worl	Yes 2 □No	28d. Describe how	injury occurred	
UIVISION	Atten deal ctor	fica	3 Suicide 6 Could not be 28e. Place of Injury - A	it home, farm, stre			28f. Location (Stre	et and Number or Ru	iral Boute Number
$\leq$	al or a after	Certification:	4 ☐ Homicide determined building, etc. (Sp	ecify)			City or Town,		,
	Hospit Hours Funera tely fille		29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (C	knowledge, death	occurred at the til	me, date and place, ppinion, death occur	and due to the car red at the time, dat	use(s) and manner as e and place, and due	s stated.
	To the Hospital or Attending P. within 24 hours after death. To the Funeral Director. After the completely filled in by the funeral.	Medical	one) and manner stated.  29b. Signature and title of certifier		29c. Licens	<u> </u>		d. Date signed (Monti	
	2		> K-swansmon	2	D5336	7	C.	ptember 9	2009
			30. Name and address of person who completed cause of death (	Item 23a) (Type, F		,	36	prember 9	, 4007
			Shyamsundar Rajan 9801 Geor	gia Aven	ue, Suit	e 117; Si	lver Spri	ing, MD 20	902
	Star Registra		31. Date filed (Month, Day, Year) SEP 18 2009 33 Registrar's Si	gnature	4.1				
	negistra	त्रा	- LUUJ KERSUR	p. jana	S. A. Barrer				

DHMH 17 Rev 1/2001

		,	State of Maryland / Dep	artment of H				09 31435
			Decedent's Name (First, Middle, Last)		Death	2. Date of Deat		3. Time of Death
ŧ,	Physici /Medic		Giuseppe Celia aka Joseph Celia			Septem	ber 16,	
	Examin	er	4a. Facility Name (If not institution, give street and number)  11910 New Hampshire Avenue		r Location of Death rer Spring	r	4c. County of	Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth	YDeath	Birthplace (State or Foreign Country)
ļ.	Director		579-40-4867	Monaro Bayo		Feb. 1	<del>4,</del> 1915	Sicily, Italy
	ryland how	L	10a. State 10b. County 10c. City, Town or L	ocation				10d. Inside City Limits
	he Ma 28a-f s	Director		ver Sprin	g			1 ☐ Yes 2X No
	3a or 2		10e. Street and Number 11910 New Hampshire Avenue	10f. Zip Code	20904	1	Og. Citizen of Wh	at Country?
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "sedent Event har mast be not filled at	Funeral		Was Decedent of H If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race -	- American Indian, White, etc.
36	rs after	by Fu	1  Never Married 2  Married 1  Yes 2  No If Yes, Give 3  Year or Dates:	1 □ Yes 2 1 No	Specify:	,	Specify	White
21215-0036	2 hour	ted	15. Decedent's Education 16a. Dece	edent's Usual Occup	pation		16b. Kind of Busi	
121	vithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done of DO NOT use retired	auring most of worki d)	ng		
	filed w Hygie other t	ပ္ပ	8 Carpen 17. Father's Name (First, Middle, Last)	ter	18. Mother's Name	e (First, Middle, I		novations
/lan	should be filed vand Mental Hygies marked other is marked other inmatic event, in	To Be	Giovanni Celia		Rosa M	lurata		
Maryland	2 sho h and I is ma rauma	ľ		ing Address (Street				tate, Zip Code) ring, MD 20904
ď	1 and Health tem 27 other ti			osition (Name of ematory or other place			20c. Location - Ci	
altimore,	Pages nent of int: If ii		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☑ Other (Specify) entemperate  Gate of		Sept 200	21	Silver S	pring, Maryland
Balti	permit. Pages: Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licensee	2. Name and Addres	ss of Facility. Collins	Funeral	Home In	C
	<u></u>	118	23a. Part 1. Byter the disease, or complications that caused the death. Do not er	OO OHIVEL	SICY DIVO	· W., D.	river sb	ring, MD 20901
t.	Physician	1	shock, of heart failure. List only one cause on each line.			or reopriatery arr	000,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  Chronic Myelocyti  Due to (or as a consequence of):	5 Leukemi	a			
	Examiner	ř	Sequentially list conditions, if any leading to immediate b.  Due to (or as a consequence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or Injury that initiated events  b. Due to (or as a consequence of): cause (Disease or Injury that initiated events					
, 0	icate be executed physician and the burial-transit		resulting in death) Last  Due to (or as a consequence of):					
98/80		dical	d					
Box	death certifi e attending p d for use as	sician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date	of delivery
Ö.	e death the atte	sicia	in the past 12 months?  1   Yes 2   No	☐ Ectopic pregnance ☐ Other (specify)	У		Monti	h Day Year
J.	that the ed by th detache	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause giv	en in Part I.	23e, Did tol	bacco use contrib	oute to the cause of death?
Records,	w requires that the d been signed by the should be detached	d by	Chronic Urinary Tract Infections, F					☐ Probably 4 🔀 Unknown
ပ္	as a	Completed	Diabetes Mellitus			24a. Was a		ere autopsy findings available
_	The ate h	Com				autops perforr 1 □ Yes	med? de:	or to completion of cause of ath? ∃Yes 2 ⊟No
VII a	iding Physician: The th. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?  1 □ Yes 2 ♣ No  Hospital: 1 □ Inpatient 2 □ FB/Outpatie	ent 3 🗆 DOA Othe	26. Place of Death			
0	g Phy er this	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	III 3 DOA	4 LI Nursing Ho		ence 6 Other	(-)//
SIO	tendin eath. or: Aff the fur	catio	2 Accident investigation		Yes 2 □ No			
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		28f. Location (St City or Town	treet and Number n, State)	or Rural Route Number,
_	ospital hours uneral ly filled		29a. Certifier Certifying Physician: To the best of my knowledge, dea	th occurred at the tir	me, date and place,	and due to the c	ause(s) and man	ner as stated.
	the Ho hin 24 the Fu	Medical	(Check only one) 2			1		
	D S S		29b. Signature and title of certifier  Rahert Helliaud MD	29c. License	e number D55522			(Month, Day, Year) r 17, 2009
,	3		30. Name and address of person who completed cause of death (Item 23a) (Type,					
			Robert H. Girard, MD 1500 Forest G.  31. Date filed (Month, Day, Year) 32. Registrar's Signature		Silver S	pring, M	4D 20910	
	Sta Registra		SEP 18 2009 Senut S. Seast	2				
		_						

State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Maryland	-	rtment of F tificate of l			ene g. No.() (	31435		
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last)  James P. Carter					2. Date of Death Month Septembe	Dav Year	3. Time of Death 9 4:30 p M		
	Examir		4a. Facility Name (If not institution, give s Montgomery Hospi		e	•	Location of Death	<u> </u>	4c. County of Death  Montgomery			
I	Funeral Director		Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 9,	Year) 9. Birt	hplace (State or Foreign untry) th Carolina		
	aryland show	Ļ	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loc	cation				10d. Inside City Limits		
	he Ma	Director	Maryland Montgom	ery	Rockv	_				1 □Yes 2 🔀 No		
	with t		10e. Street and Number 15204 Hannans Wa	•		10f. Zip Code 20853		10	g. Citizen of What Co USA	untry?		
	d 2 should be filed within 72 hours after death with the Maryland than Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examination to the control of the death.	Funeral		y 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No	3. 13. V		ispanic Origin? (Sp ın, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White			
215-0036	hours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	16a, Deced	☐Yes 2 <b>x</b> No ent's Usual Occupa	Specify:	11	Specif Blac			
21215	I within 72 giene. r than "na Ine Meali	Completed	(Specify only highest grade Elementary/Secondary (0-12) 1.2	Completed) College (1-4or 5+)	(Give F life. D	kind of work done of NOT use retired o Repair	during most of worki ()	ing	Automoti	,		
Maryland ;	ld be filed fental Hyg ked othe lic event,	To Be C	17. Father's Name (First, Middle, Last) William H. Carte	r			18. Mother's Name Joseph	(First, Middle, Ma	aiden Surname)			
	and 2 shou ealth and N n 27 is mai ner traumai		19a. Informant's Name/Relationship (Type Estelle Carter/Wi		1				City or Town, State, 2	Zip Code)		
Baltimore,	- I 2 2 2	1	20a. Method of Disposition  P☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		ace of Dispos emetery, crem	sition (Name of atory or other place Memorial	e) Sep	Date 19	Oc. Location - City or			
Balti	permit. Pages Department of I Important: If ite any Injury or o		21. Signature of Funeral Service License	е	22. Fi	Name and Addres	ss of Facility Collins	Funeral	ockville, Home Inc.	Maryland ng, MD 20901		
* ~	Physician		23a. Part1. Enter the disease, or complict shock, of heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death. e cause on each line.  Metastatic Pr	. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death		
	/Medical Examiner	L	resulting in death)  Sequentially list conditions,  b.	Due to (or as a conseque	ence of):							
٥٥, ٥٥	tificate be executed g physician and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate sauss. Liner understying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Cu. Due to (or as a consequence of):									
08/PU	tificate g phys as the	edical	d									
×	attendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal   4 □ Pregnant at time of de 9 □ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)	1		23d. Date of del Month	ivery Day Year		
ecords, P	The law requires that the death ate has been signed by the atter page 2 should be detached for u	by	Part II. Other significant conditions con	ributing to death but not resul	ting in the un	derlying cause give	en in Part i.		acco use contribute to	the cause of death?		
n Reco	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed						24a. Was an autopsy performe	prior to o	topsy findings available completion of cause of		
Z .	ician certifi ector,	Be	25. Was case referred to medical examiner?	ospital:		Othe	26. Place of Death					
VISION OI	ding Phys	ion: To	27. Manner of Death  13 Natural 5 Pending	1   Inpatient 2   E	R/Outpatient 28b. Time of Injury	28c. Injury Work	at :	me 5 Residen 28d. Describe how	ce 6 XOther (Special injury occurred	eify) Hospice		
	To the Hospital or Attending Physician: within 24 hours after death within 24 hours after death and the Funeral Director: After this certifica completely filled in by the funeral director, to	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre		∕es 2□No	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,		
	re Hospits 24 hours re Funera	Medical C	29a. Certifier (Check only one)  Certifying Phys 2 Medical Examin	ician: To the best of my know er: On the basis of examinati and manner stated.	/ledge, death on and/or inv	occurred at the time estigation, in my op	ne, date and place, pinion, death occurr	and due to the car red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)		
<b>)</b>	Some Some	Ň	29b. Signature and title of certifier	hou, mi		29c. License D 63	number 748		d. Date signed (Month September	n, Day, Year) Lir 16, 2009		
7			30. Name and address of person who cor Jocelyne Kouatch				#100, Ro		MD 20850			
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	lire base	2.0		-	-			

DHMH 17 Rev 1/2001

**Physician** /Medical Éxaminer

**Physician** 

/Medical

Examiner

Directo

Funeral

þ

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matitude.

Baltimore, Maryland 21215-0036

and burial-tran physician the as attending p been signed by should be detac has

Examine O_L Certification:

Physician/Medical ð Completed

Be

The law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours a er death.

To the Funeral Director After this certified completely filled in by the funeral director, t

Division or Vital Records, P.O. Box 68760,

State Registrar

25. Was case referred to medical examiner? 1 ☐ Yes 2X No 27. Manner of Death 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 29a Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Mitta Shama

and manner stated.

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

D0061382

September 14, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Shama R. Mittal, M.D.

14816 Physicians Lane; Rockville, MD 20852

31. Date filed (Month, Day, Year) 18 SEP

32 Registrar's Signature

		For State Registrar				•	tificate of	Health and Death		Reg. No.	0 01:00
Physici	an	1. Decedent's Name	e (First, Middle	, Last)					2. Date of De Month	Day Yea	R.A
/Medi	cal	Julia We		Clark , give street and number	-)	Ī	4h City Town o	or Location of Deat	Septemb	er 10, 200	
Examir	ner	William			/		Easton	of Location of Deal	uı	Talbo	
Funeral		5. Social Security N		6. Sex 7. A	ge (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th 9.F	Birthplace (State or Foreign Country)
Director		245-56-0		1□ M 2 <b>X</b> F	98	Yrs.	WOTHIS Days	Tiodis Iviii.			North Caroli
MO to		Usual Residence of 10a. State	10b. County		10c. City, 7	Town or Loc	cation				10d. Inside City Limits
a-f sh	ż	MD	Tal	lbot		xford	1				1 □Yes 2 <b>X</b> No
or 28	Director	10e. Street and Nur				ALUIC	10f. Zip Code			10g. Citizen of What	Country?
Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exemptor must be rediffied at orce.		4791 Sa:	ilors R	etreat Road			2165			USA	
items	Funeral	<ol> <li>Marital Status</li> <li>Never Marri</li> </ol>	ind OF Marri	12. Was Deceden Armed Forces ied 1 □Yes 2	?	13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Race - Al Black, W	merican Indian, hite, etc.
al", or	5	3 X Widowed		If Yes, Give Year or Dates		1	□Yes 2 <b>X</b> No	Specify:		Specify:	White
natura lical E	Completed	(Spec	15. Decedent	's Education It grade completed)	- J	16a. Deced	lent's Usual Occup	pation	rkina	16b. Kind of Busine	ss/Industry
ne, han "ı	mple	Elementary/Seco		College (1-4or	5+)			during most of wo			
Hygie ther ti		17. Father's Name	/First Middle I	2		Acco	unting/B	ookkeepe:		Retail/T , Maiden Surname)	ravel Agency
c eve	o Be							Ione I	,	, Maidon Garnamo)	
mari umati	ဥ	19a. Informant's Na				19b. Mailin	g Address (Street			er, City or Town, State	e, Zip Code)
n 27 is er tra		Edgar Be	ellinge	r Son-in-	law	4791	Sailors	Retreat	Road - O	xford, MD	21654
r oth		20a. Method of Disp	position	3 ☐ Removal from State	20b. Plac	e of Dispos netery, crem	sition (Name of natory or other pla	ce)	Date	20c. Location - City	
tment tant: I jury o			5 ☐ Other (Sp		Ches			ion   09/			ville, MD
Dupar Impor any in		21. Signature of Fu	uneral Service L	^ ^	0.00	Fe Fe	. Name and Address $11 {\sf ows}$ , $ $	ess of Facility lelfenbei	n & Newn	am Funeral	Home, P.A.
		23a Part1 Enter t	the disease or a	complications that cause		411				Easton, N	D 21601 Approximate
		shock, or hea	art failure. List o	only one cause on each	line.	Do not cine	or the mode of dy.	ing, odori do odraio	io or respiratory a		Interval Between Onset and Death
ysician /ledical		disease or condition resulting in death)	on	a. Due to (or a	s ayconsequer	nce of):	norua				Iwa
aminer				. le	triet	we	Lung	Diseas	e		10 years
.=	iner	Sequentially list con if any, leading to im cause. Enter Unde	erlvina	Due to (or a	s a consequer						
and I-transit	Examiner	Cause (Disease or that initiated events resulting in death) I	injury S	c	s a consequer	200 of\.		,			
cian Juria		, country in accuracy			s a consequer	ice oi).					
attending physici for use as the bu	edic			d							
ending use a	II/M	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outcom			15.			23d. Date of	delivery
ed for	sicia	in the past 12 1 ☐ Yes 2 ☐	months?	4 Pregnant	2 ☐ Fetal de at time of dea		Ectopic pregnand Other <i>(sp</i> ec <i>ify)</i> _	су		Month	Day Year
d by the	Physician/Medical	9 Unknown		9 Unknown					00 5111	<u> </u>	. A. Aba asymptotic (1971)
signe(	þ	Part II. Other signif	rent condition	ns contributing to death	but not resultir	ng in the un	iderlying cause gi	ven in Part I.			e to the cause of death?  Probably 4 Unknown
been	Completed	12.	4000	men de							
certificate has birector, page 2 s	ldu		(acop	W 035					24a. Was auto		autopsy findings available to completion of cause of
ifficate or, pa		25. Was case refer	red to medical	Tension				06 Place of Da	1 □ Yes	2 ☑No 1 □ 1	
is cert direct	To Be	examiner?	/	Hospital:	tient 2 EF	R/Outpatien	t 3 DOA Oth	nor:	eath <i>(Check only c</i> Home 5 ☐ Resi	idence 6 Other (S	Specify)
ter thi		27. Manner of Deat		28a. Date of In		3b. Time of Injury	28c. Inju			how injury occurred	респу
r Af	atic	2 Accident	5 Pending investig	ation	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,		Yes 2□No			
. 0 =	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	Zoe. Place of I	njury - At home etc. <i>(Specify)</i>	e, farm, stre	eet, factory, office		28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,
irecto n by th	0)	20a Cortifior	1 Cawifuin	a Physician. To the bea	t of my knowle	adaa daath	and irred at the	imo dota and plac	and due to the	a a usa /s\ and manna	v an otated
eral Directo		29a. Certifier		g Physician: To the bes	of augmination	n and/ar in	enationation in more	aminiam death and	and a second second	data and place and	dire to the engine (a)
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within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the temporal page.		one) 29b. Signature and	2  Medical E	and manners	lens	P)	29c. Licen:	se number		29d. Date signed (Me	onth, Day, Year)
15		29b. Signature and	title of certifier	and manner	Uup death (Item 2	3a) (Type, F	29c. Licens	se number	- L	29d. Date signed (MI	onth, Day, Year)
within 24 hours after der  To the Funeral Directo  completely filled in by th	Medical	29b. Signature and	title of certifier  www.le  ress of person w	and manners	death (Item 2)	3a) (Type, F	29c. Licens HY Print)	se number 2587 d & E	aston		2009

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinar must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 - State Registrar	State of Maryland /	-	ficate of i		a momarri	Reg. No	-		
Decedent's Name (First, Middle, Last)		· · · · ·			2. Date of D	eath		Van	3. Time of Death
William G.	Christian, Jr.				Sept	16,	^{ay} 2009	Year	1:25 Ам
4a. Facility Name (If not institution, give s 5087 Temple Hills			o. City, Town, or Temp1e		eath		c. County P <b>rin</b> c		orge's
311 02 9332 A	7. Age (In yrs. last I		Under 1 Year onths Days	If Under 24 Hours M	Hrs. 8. Date of B Min. (Month, U Sept 6	orth Day, Year D, 19	346	9. Birthp Coup Wash	lace (State or Foreign try) nington DC
Usual Residence of Decedent  10a. State  10b. County  Maryland Prince Geo	orge's	Temp1e	Hills			1 □Yes 2			0d. Inside City Limits 1 □ Yes 2√√No
10e. Street and Number	:11a Dood		10f. Zip Code 20748	Ω		_		Vhat Coun	•
5087 Temple H:  11. Marital Status  1 □ Never Married 2XXMarried  3 □ Widowed 4 □ Divorced	I2. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2  No If Yes, Give	If Ye	Decedent of H	lispanic Origin	? (Specify Yes or Nuerto Rican, etc.)		14. Rac Blac	e - Americ k, White, e	an Indian, etc.
15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation 16 completed) College (1-4or 5+)	Ga. Decedent (Give kind life. DO	t's Usual Occup d of work done o NOT use retired	during most of d)	working	P		usiness/Ind	,
17. Father's Name (First, Middle, Last)		etter	Carrie		Name (First, Middi				Service
William Gibbon	s Christian , S	r.		Vir	ginia Ma	ay Gi	riffi	.n	
19a. Informant's Name/Relationship (Type Constance Chris	tian (Wife)	9b. Mailing A 5087 T	Cemple H	Hills R	r Rural Route Num oad, Temp	ole H			
20a. Method of Disposition  1)XXBurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)			on (Name of ory or other place Nationa		21, 2009	I -	_	City or To	wn, State aryland
21. Signature of Funeral Service License	B	22. N	ame and Addre	ss of Facility		ral I	Home,	Inc	. 6633 Old
23a. Parl . Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	LLUN			STAGE				Approximate Interval Between Onset and Death
Sequentially list conditions, if a y least conditions, if a y least conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy  1  Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		ctopic pregnanc	у				te of delive	ery Day Year
Part II. Other significant conditions con	tributing to death but not resulting	in the under	rlying cause giv	en in Part I.			use cont	ribute to th	ne cause of death?
					24a. Wa — aut per 1 □Yes	opsy formed?		prior to co death?	psy findings available mpletion of cause of 2  No
25. Was case referred to medical examiner?	ospital:	~ · · ·	Oth	Or:	Death (Check only				
	1 ☐ Inpatient 2 ☐ ER/		Time of 28c. Injury at 2 Injury 2			Home 5 Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred			y)
1 ☐ Yes 2 ☐ No Ho  27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	Injury		yai k? Yes 2∐No					
1  Yes 2  No Ho  27. Manner of Death 1  XNatural 5  Pending	28a. Date of Injury (Month, Day, Year) 28b. 28e. Place of Injury - At home, building, etc. (Specify)	Injury	M 1 🗆					er or Rura	al Route Number,
1 Yes 2 No Ho  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier 1 Certifying Phys	(Month, Day, Year)  28e. Place of injury - At home,	Injury farm, street,	M 1 ☐ factory, office	Yes 2 □ No me, date and p	28f. Location City or To	own, Sta	(s) and m	anner as s	stated.

BB100

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

MATILDA H. 1221 31. Date filed (Month, Day, Year) SEP 18 2009

MERCANTILE LANG, LARGE, MD. 20174 62. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death 4:00 A.M September Willie Lee Collins 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Fort Washington Hospital Fort Washington 5. Social Security Number 6. Sex 1 **X** M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Months Days Hours 66 247-72-5857 10/04/1942 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12100 Lihou Court 20744 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 XYes 2 \sum No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🙀 Married 1 ☐Yes 2 X No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 72 Accountant Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Northrup Collins Ruth Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Collins/Wife 12100 Lihou Court, Ft. Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/21/2009 | Cheltenham, MD <u>Marvland Veterans</u> 21. Signature of Funeral Service 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acrise Myoc disease or condition resulting in death) Due to (or as a consequent of): COTOKONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

_≽Physician /Medical Examiner

and

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be ဥ

**Funeral** 

Director

filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show

Pages 1 and 2 should be filed venent of Health and Mental Hygic ant; If item 27 is marked other it...

permit. Pages 1 and Department of Health Important: If item 27 any injury or other troone.

Baltimore, Maryland 21215-0036

?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, Ir e Madical Examinar must be notified.

burial-tran attending physician for use as the buria detached رمان nas been signed , page 2 should be det funeral director,

Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Physician/Medical Examiner þ Completed Be Medical Certification: To filled in by

certificate has

this

After

or Attending

To the Hospital or Attend within 24 hours after death To the Funeral Director:

autopsy performe 1 ☐ Yes 2 No 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 3 Suicide 6 Could not be

4 Homicide

29a. Certifier (Check only one)

25. Was case referred to medica

1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

determined

29c. License number DO05311

2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICK DALY 11711 LIVINGSTON ROAD, FORT WASHINGTON MD 31. Date filed (Month, Day

Registrar

SEP 2 1 2009

Ammend Box #8 Per F.D. 9/22/09 Carroll County Health Dept W.S.H. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylan		rtificate of l			teg. No.	119	31491	
l	Physici		Decedent's Name (First, Middle, La  Ma	st) ry Jane Dríver				2. Date of Dea Sept. 1		Year	3. Time of Death 3:50pm M	
	/Medid Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	вере. 1	4c. County of			
4100			1715 Amberly Co  5. Social Security Number 6. 9		la at birth day ()	Ma If Under 1 Year	rriottsvi If Under 24 Hrs.		20		arroll  place (State or Foreign	
	Funeral Director			M 2 X F 85	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day June 25	, 1924	Coun	place (State or Foreign htry) NY	
	yland		10a. State 10b. County		y, Town or Lo			-		1	Od. Inside City Limits	
	ne Mar 18a-f si	ector		roll		Marriot	tsville			1 ☐ Yes 24 ☐ No		
MD Carroll Marriottsville    Mode									I0g. Citizen of W	g. Citizen of What Country?  USA ~		
980	should be filed within 72 hours after death with the Maryland and Mental Hyglene. s marked other than "natural", or items 23a or 28a-f show umatic event, if a Pydical Emirica must be notified a		11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.s Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2☐ No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	- Americ , White, e		
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land	N PORT TO THE MARKET  17. Father's Name (First, Middle, Last)  Donaldson Cleveland  18. Mother's Name (First, Middle, Last)  Eleanor									)		
Mr. Donald Barnett (Executor) 12213 Captains Court Woodbr  20a. Method of Disposition 1												
Balt	permit. Depart Import any Inj once.	21. Signature of Funeral Service Licensee  22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, P.A. PO Box 195 Sykesville, MD 21784										
	executed / Medical Examiner   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and   In and	Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or figure that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence o	uence of):	er the mode of dyin	g, such as cardiac	or respiratory arr	rest,	b	Approximate Interval Between once and Death	
O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d	death 3	Ectopic pregnancy	/		23d. Date of delivery Month Day Year			
rds, P.	quires that the de n signed by the a uld be detached t	þ	Part II. Other significant conditions of	contributing to death but not resu	Ilting in the ur	nderlying cause give	en in Part I.	1			ne cause of death?	
Records,	The law require ate has been sig age 2 should b	Completed						24a. Was a autops perfor	meg? pr	rior to cor eath?	psy findings available mpletion of cause of	
Vita	sician: The certificate h rector, page	BeC	25. Was case referred to medical 26. Place of Death (Check unly one)									
Division of Vital	ding Physi h. After this c funeral din	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
Divisi	To the Hospital or Attend within 24 hours after death.  To the Funeral Director: /	27. Manner of Death 1									l Route Number,	
29a. Certifier  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  29a. Certifier  (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date-signed (Month. Day, Year)								tated. the cause(s)				
<b>B</b>	<b>パン</b>	Ž	29b. Signature and title of certifie	7		29c. License	Jo?	2	9d. Date signed	Month,	Day, Year)	
	6		30) Name and address of person who	completed cause of death (Item	S. I			Anes	7	,		
	State Registrar  SEP 18 2009 Review A. Sould											

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year 4=308M calvin S. Dorsey sept 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Medical Maryland center Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Days 1 M 2 □ F Months Hours Min. 215-32-5877 MD January 18, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No MD Sykesville Carroll 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7615 Norris Avenue 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 May Yes 2 No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May No. 1 May Black, White, etc. 1 Never Married 2 Married л **Y**es, Give 1957**–**61 Year or Dates: 1 □Yes 2 No Specify. Specify: Black 6 4 1 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief Steward Dietary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Clifton Dorsey Sarah Norris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Vivian L. Dorsey (Wife) 7615 Norris Avenue Sykesville, MD 21784 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/18/2009 St. Lukes Cemetery Sykesville, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, P.A. tuin MO0764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonar disease or condition resulting in death) suspected Due to (or as a onsequence of): unknom Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Director

Funeral

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item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinar must be inclined at

filed within 72 hours after death with Hygiene.

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Important: If item
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Baltimore, Maryland 21215-0036

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P.O. Box 68760,

Records,

Examiner

Physician/Medical

The law requires that the death certificate be executed been signed by the should be detached cate has l page 2 s death.

**Division of Vital** Hospital or Attending Physician: To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu WIL

ed by		with builing to doubt but not 100	nothing in the dilucitying	g caase given in arti.	1 ☐ Yes 2[	□ No 3□ Probably 4 ☑ Unknown	
Completed					24a. Was an autopsy performed? 1 ☑ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No	
Re	25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)		
0	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 □	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	6 ☐ Other (Specify)	
	27. Mann of Death 1 ☐ atural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred	
Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specific	ome, farm, street, factory)		<ol> <li>Location (Street and Number or Rural Route Number, City or Town, State)</li> </ol>		
Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exami	vsician: To the best of my knowiner: On the basis of examination and manner stated.	owledge, death occurnation and/or investigati	ed at the time, date and pla on, in my opinion, death or	ace, and due to the cause(s)	and manner as stated. place, and due to the cause(s)	
ž	29b. Signature and title of dertifier		2	29c. License number	29d. Dat	e signed (Month, Day, Year)	

29c, License number M.D 1649405515 29d. Date signed (Month, Day, Year) 12, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Coreene St

University NGUYEN

State Registrar

31. Date filed (Month, Day, Year)

09-07218 William Dauer

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State	Certificate of Death	Reg. No.	
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
Medical Examine		4b. City, Town, or Location of Dea	September 15, 2009	05241115
	4a. Facility Name (if not institution, give street and number) 5903 Hanna Road	Eldersburg	Carroll	
Funeral Director	285-34-5454 ₁ X _{M 2} F 68	n yrs. last birthday) Yrs.  If Under 1 Year   If Under 24H Months   Days   Hours   M	Irs. 8. Date of Birth (MM/DD/YYY) Iin. Oct. 19 1940	y) 9. Birthplace (State or Foreign Country) OH
any	100.000	c. City, Town or Location		10d. Inside City Limits
Aaryland 28a-f show any 1 at once ector	MD Carroll	Sykesville		1 Yes 2 XNo
th the Marylan 23a or 28a-f sl notified at onc	10e. Street and Number 5903 Hanna Road	10f. Zip Code 21784	10g. Citizen of W USA	
r death wir or items a must be a	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Every Armed Forces? 1 Yes 2	If Yes, specify Cuban, Mexican, Puer	rto Rican, etc.) Whi	e-American Indian, Black, te, etc. white
ours afte	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	ted) 16a. Decedent's Usual Occupation (Give kind o	of work done 16b. Kind of B	susiness/Industry
6 72 hou ra "nat cal Exa		during most of working life. DO NOT use r	Merck	& Co.
5-0036 ed within 72 ho tygiene. other than "na the Medical Ex	17. Father's Name (First, Middle, Last)	assistant manager	me (First, Middle, Maiden Surnam	e)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	John Joseph Dauer		ide Alice Krebs	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after rent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Completed by	19a. Informant's Name/Relationship (Type, Print) Mary Elizabeth Dauer (spous	e) 19b. Mailing Address (Street and Number of	esville, MD 2178	34
<b>2</b>	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)		- City or Town, State
Baltimore, permit. Pages 1 at Department of He Important: If ite	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	All County Cremation 9-	the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon	rille, MD
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Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for underlical Certification: To Be Completed by Physic		nowledge, death occurred at the time, date and place, a nation and/or investigation, in my opinion, death occurre	and due to the cause(s) and manned at the time, date and place, and	ner as stated. If due to the cause(s)
	29bSignature and title of certifier	29c. License number		gned (Month, Day, Year)
WIL E	amm 1	O.C.M.E.	Septemb	er 15, 2009
	30. Name and address of person who completed cause of dea Zabiullah Ali, M.D. Assistant Medical Exa	` _	21201	
State		Signature A. Sark		
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			1- For State of Maryland / Dep Registrar Ce	artment of Health and Martificate of Death		2007	31494
	Physici /Medio		1. Decedent's Name <i>(First, Middle, Last)</i> EARLY LOUISE DOSS		2. Date of Death Month September	ay Year	3. Time of Death P
	Examir		4a. Facility Name (II not institution, give street and number) 2005 PENFIELD LANE	4b. City, Town, or Location of Death	P	c. County of Death RINCE GI	
	Funeral Director		5. Social Security Number  6. Sex 1 M XXF 7. Age (In yrs. last birthday, 73 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea 07-13-19		ace (State or Foreign try) TEXAS
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920	within 72 hours after death with the Maryland ane. than "netural", or items 23a or 28a-f show he Madical Examiner must be outliked at	by Funeral Director	Married 2 Married Married Married Married Married Married 2 Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married Married M	Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes XX No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	etc.
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	and 2 sho salth and n 27 is m	1 8	19a. Informant's Name/Relationship (Type, Print) THOMAS F. ECHOLS / COUSIN 4813	ng Address (Street and Number or Run RICKEE DRIVE,	A Route Number, City FORT WOR	or Town, State, Zip TH, TEXA	^{Code)} AS 76115
Baltimore,	. Pages 1 tment of He tant: If iten jury or oth		4 Donation 5 Other (Specify) CREMA	TE PARK FORY 20	09 ¹⁸ , R	Location - City or To	E, MD
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8760,	Physician /Medical Examiner wisician and per particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its particular its partic	licai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	tic CardioVAS	cufor A	feart D.	Approximate Interval Batween Onset and Death
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			For State Registrar	State of Ma	aryland		rtment of l tificate of		nd Ment	al Hygie Reg.	property of the	11.05
			Decedent's Name (First, Middle, Last				ate of Death	Day Year	3. Time of Death			
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	deat ms 2	ne.	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	i. 13. V	Vas Decedent of Yes, specify Cub	Hispanic Origin	n? (Specify Y	es or No-	14. Race - Ame Black, Whit	
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lar	Ald be Aenta rked tic ev	ToE	Edwin Evans					Cora	Kather	ine Co	rbin	
Maryland	small suma	ľ	19a. Informant's Name/Relationship (	Type. Print)		19b. Mailin	g Address (Stree	and Number	or Rural Rou	te Number, Ci	ity or Town, State,	Zip Code)
	and 2 ealth n 27 I		Evelyn Louise Evar	ns (Wife)					Crisfi		aryland	
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Romaval from State	20b. Pla	ace of Dispos metery, crem	sition (Name of atory or other pla	ce)	Date	200	. Location - City or	Town, State
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Specify		Sal:	isbury	Cremato	ry Se	pt. 14	, 2009	Salisbu	ıry, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exymination on the reconstitution once.		21. Signature of Funeral Service Liber	Ichnot	1	4	Name and Addre	- 1			ONS FUNER	
			Markit Both Braze 23a. Part 1. En er the disease, or com	chaw-Dru	the death	-					eld, MD 2	21817 Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	ne.	. Do not crite	in the mode of dy	rig, saori as sa	araido or roop	matory arroot,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. <u>Cardio</u> Due to (or as			Failure					
	Examiner			h Left Bi	·		Carcin	oma				
	P +	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as			COLCII	ionia			100	
	ecuter nd transi	Examiner	Cause (Disease or injury that initiated events	c. COPD								
90,	oe execian a	ũ	resulting in death) Last	Due to (or as	a conseque	ence of):						
68760,	ficate be executed physician and s the burial-transit	edical		.d								
9 x	h certifi ending   use as		IF FEMALE:	23c. If yes, outcome	of pregnan	new .						
Вох	eath certifi attending   for use as	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pregnan Other (specify)	су			23d. Date of de Month	Day Year
0	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use a	Physician/M	1 □Yes 2 □No 9 □ Unknown	9 Unknown	t time of de	Juli 5 E	Other (apeciny)					
о. С.	that ned b deta		Part II. Other significant conditions of	ontributing to death b	ut not resul	ting in the un	derlying cause gi	ven in Part I.	2	3e. Did tobac	co use contribute t	o the cause of death?
Records,	w requires to been signer should be a	D D	Atrial Fibrilla	tion						1 🔀 Yes	2 No 3 F	robably 4 🗆 Unknown
၀	s bee	Set	Urmoutonaion						2	4a. Was an	24b. Were a	utopsy findings available
æ	The faw te has rage 2 s	Completed by	- Hypertension						_  .	autopsy performed □Yes 2 √x	rformed?   death?	
Vital	sician: The certificate h rector, page	BeC	25. Was case referred to medical examiner?					26. Place of	of Death (Che		1010	2 🗔 110
of V	hysic nis ce I direc	일	1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	R/Outpatien	3 □ DOA Otl	ner: 4 🗆 Nursi	sing Home	5 🔀 Residence	e 6 □Other (Spe	ecify)
	ding Ph h. After th funeral		27. Manner of Death 1 ▼Natural 5 Pending	28a. Date of Inju (Month, Da	ry y, Year)	28b. Time of Injury	28c. Inju Wo			Describe how i	njury occurred	
sio	Attending F er death. rector: After by the funer	cati	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be					]Yes 2□No				
Division	2 P = C	Certification:	4 Homicide determined	28e. Place of Inju building, etc	c. (Specify)	) }	et, ractory, office		281. L	ity or Town, S	t and Number or H tate)	lural Route Number,
	Hospita 4 hours Funeral tely fille	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis o and manner sta	f examinati	/ledge, death on and/or inv	occurred at the trestigation, in my	ime, date and opinion, death	place, and do	ue to the caus the time, date	se(s) and manner a and place, and du	as stated. e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	~			29c. Licen	se number		29d.	Date signed (Mon	th, Day, Year)
	111		▶ W(	July MD				0001571	.5		Septemb	er 14, 2009
	10		30. Name and address of person who							7 7/2	01017	
	Sta	te	William Gil 31. Date filed (Month, Day, Year)	32 Registra	ar's Signati	ire		e - Cri	ısııel	a, MD 2	7ΤΩΤ \	
	Registr		SFP 14	2009	wa	1. 4	back					
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DHMH 17 Rev 1/2001

	•	For State Registrar		Sta	ate of ivi	aryıan		artment of F rtificate of		ia ivicitai i	Reg. No.	000	3149	
hysicia	an	1. Decedent's Name								2. Date of I	Death Day	Year	3. Time of Death	
Medic	al	Elleanor  4a. Facility Name (If I						4b. City, Town, o	r Location of F	Death De				
amin	ег	PENINSULA	-	TONAL	Mesic		Centa	4B. Oldy, lown, o	SAU 3.	6414		,		
al		5. Social Security Nur 465–48–59		6. Sex 1 ☐ M 2			last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month,	Birth Day, Year)	Cot	intry)	
r		Usual Residence of D	Decedent			73				11/28	11933			-
	'n		10b. County			10c. Cit	ty, Town or Lo							
	Director	MD 10e. Street and Numb		albot		<u> </u>	Eas	ton 10f. Zip Code			10g. Citizei	n of What Cou		-
	a D	6690 Ног	pkins	Neck F	load			216	601			USA	1	
	Funeral	<ol> <li>Marital Status</li> <li>Never Marrie</li> </ol>	d 2 <b>∏</b> Mar	ried Ar	as Decedent med Forces? ⊒Yes 2 <b>K</b>			Was Decedent of H		? (Specify Yes or ruerto Rican, etc.)		Black, White	, etc.	
	d by	3 ☐ Widowed 4		Ye	res, Give ar or Dates:			1 □Yes 2 <b>X</b> No	Specify:			ocony.		
	plete	(Specif	y only highe	t's Education st grade com	pleted)		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	oation during most of d)	working	16b. Kind	of Business/I	ndustry	
	Completed	Elementary/Second 12	dary (0-12)	Co	ollege (1-4or 9	o+)		memaker			O	wn Home	2	
1	Be	17. Father's Name (F		Last)						Name (First, Midd		rname)		
	은 .	W.Q. Wa		hip (Type. Pr	int)		19b. Mailir	ng Address (Street			-	own, State. Z	ip Code)	-
		Clifton W				<b>d</b>		90 Hopki						_
		20a. Method of Dispo 1 ☐ Burial 2 🛣	Cremation		al from State	٠ ا	cemetery, crei	sition (Name of natory or other plac		Date		•		
•	-	4 ☐ Donation 5				Che		e Cremati		·				-
		Joseph	M.		well C.	F.51		ellows, l	Helfenb -Harrie	ein & Ne	wnam Fo	uneral	Home, P.A.	
		23a. Part1. Enter the shock, or heart	e disease, or failure. List	complication only one cau	s that caused se on each li	d the deat	h. Do not ent	er the mode of dyir	ng, such as ca	rdiac or respirator	y arrest,	year  Joog  Jits AM  John Country  9. Birthplace (State or Foreign Country)  Texas  10d. Inside City Limits 1 Yes 2 No  of What Country?  USA  Race - American Indian, Black, White, etc. ecity: White  of Business/Industry  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The Mome  The		
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ı		,			Due to (or as	a conseq		teremin					Dance	
١	iner	Sequentially list condition, leading to find cause. Enter Underly Cause (Disease or in	ditions, sollate ying	b	Ottes to (or as	а еспвыц		* ELEVELA					777	
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-1	_			d			,							
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	ician,	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐	nonths?	1 4	yes, outcome □ Live birth □ Pregnant a	2 Feta	Ideath 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су		230		,	
	hysi	9 Unknown		9	Unknown			, ,						
l	٦	Part II. Other signific		Λ.	-		ulting in the u		ven in Part I.	/	d tobacco use ☐ Yes 2.21	_		
	ompleted	- UIUIUI	(	(	24.74	<del>) ''</del>	11000	1	He. wh.	24a. W	as an	24b. Were aut	topsy findings available	_
	Comp									pe	rformed?	prior to c death?	ompletion of cause of	
l	Be	25. Was case referre examiner?		Hospita	al:			Oth		Death (Check onl				-
	٥	1 Yes 2 1N 27. Manner of Death	lo		a. Date of Inju	ıry	ER/Outpatier 28b. Time of		4 LI Nursi	ng Home 5 ☐ Re	esidence 6 De how injury o		cify)	-
	ation:	1 🗽 Natural 2 ☐ Accident	5 Pendin investi	g gation	(Month, Da	y, Year)	Injury	Wor	ḱ? Yes 2 □ No					
	Certificati	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be alned 286	e. Place of Inj building, et	ury - At ho c. <i>(Sp</i> ec <i>it</i>	ome, farm, str fy)	eet, factory, office	-130		(Street and M Town, State)	Number or Ru	ral Route Number,	
- 1	Medical Co	29a. Certifier 1 (Check only one)	Certifyir	Examiner: (	: To the best on the basis on and manner st	of examina	owledge, deat ation and/or in	h occurred at the ti vestigation, in my o	me, date and popinion, death	place, and due to to occurred at the time	the cause(s) ar ne, date and pl	nd manner as ace, and due	stated. to the cause(s)	-
	₩	29b. Signature and til	tle of certifie	10	1			29c. Licens	se number	<del>.</del>	29d. Date s	signed (Month	ı, Day, Year)	
		Mul	mon of	Dow	Nows	>		Do	5540	-7	Septe	mber	13 2009	_
		30. Name and address	ss of person	who complet	ed cause of c	leath (Iten	n 23a) (Type,	Print) 1010 A	hilford SV	10.	- V		I	
		M with A	R.	1. MA	PinD	1 .	ace II. I	110 0	1 . /	- SA/11/	101	10-01		
Stat	e	31. Date filed (Month)	Bouns Dou-Year)	<i>ls Mp</i> 1 5 200	.32. Registr	ars Signa		back Sui	Ve 405	- Salisbary	Mp 2	1801		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Janice R. Ford 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 F 217-28-2845 Yrs. 79 Director 10-03-1929 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. In Experiment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment for Inviting any once. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Somerset Westover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27370 Fairmount Road Funeral 21871 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none Clerk General Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willis Parks ٩ Beulah Meredith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greg Ford/Son 30905 Cooper Lane, Princess Anne, MD 21853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Beechwood Cemetery 9-10-2009 4 ☐ Donation 5 ☐ Other (Specify) Princess Anne, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home Ja. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11673 Somerset Ave., Princess Anne, MD 21853 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) our 0 /Medical Due to for as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause that the cause (Disease or injury that initiated events resulting in death) Last Due to / r = consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Ash fours after death.

A hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eathy filled in by the funeral director, page 2 should be detached for use as the burlansit anel. Exami attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown pate has t 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe **Division of Vital** 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 ⊡ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

within 24 hours a

To the Funeral D

completely filled i

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Tilliam

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

H. Robins, M.D. 200 Civic Ave. Dalisbur

32. Registrar's Signature

29c. License number

2180

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Emory Otto Ford 0320 2009 pot. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury Renabilitation Nursing
Social Security Number 6. Sex 7. Age (In yrs. last of isbur 8. Date of Birth (Month, Day, Year, 09-21-1925 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F 220-26-3335 83 Maryland Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director MD Somerset Westover 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 27370 Fairmount Road 21871 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Itimore, Maryland 21215-0036 1 □Yes 2 No Completed by Specify. Specify: 3 Widowed 4 □ Divorced White er than "nature the Medical E 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. none Waterman/Carpenter Seafood/Construction If item 27 is marked other or other traumatic event, ii 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otto Emory Ford Elsie Walston ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Heatth a Important: If item 27 Is any Injury or other trau Sharon Ford Daniels/daughter <u> 11114 Brownstone Road, Princess Anne, MD 21853</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Fairmount Cemetery 09-10-2009 | Fairmount, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fundal Se 22. Name and Address of Facility. Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated to the complex shock of the complex shocks. ns that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use the control of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the Approximate Interval Between Onset and Death Immediate Cause (Final Physician oardisease or condition resulting in death) 010200 /Medical Que to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to for as a consequence of, The law requires that the death certificate be executed physician and s the burial-trans Due to for as a consequence of): resulting in death) Last P.O. Box 68760. signed by the attending l IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. \$ 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown s peen si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has I lirector, page 2 s autopsy perform 2 🗆 No 1 □ Yes 2 ₽No 1 ☐ Yes I or Attending Physician: after death. within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital of within 24 hours at To the Funeral D

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H-Robins, M.D.

200C

29c. License number

29d. Date signed (Month. Day, Year)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Mona Fugitt AM18 2009 11:10 /Medical September 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Larkin Chase Prince Georges Bowie If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🕱 F Months Hours Min. **Director** 214-48-5151 94 6/2/1915 Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD Prince Georges Glenn Dale 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20769 P.O. Box 551 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No þ Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Crossing Guard Public Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Henry Wilson 2 Florence Ellen Foster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6908 Glendale Rd. Kathy Jones / Daughter Glenn Dale, MD. 20769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft.Lincoln Cemetery 9/23/2009 | Brentwood, MD. 22. Name and Address of Facility Ft. Lincoln Funeral Home Tarcos 3401 Bladensburg, MD. 20722 art 1. Enter the dise e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart fail r Immediate Cause (Findisease or condition resulting in death) Gastrointestinal Bleeding Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Examiner Due to (or as a consequence of): Physician/Medical

**Physician** /Medical Examiner

the Maryland

72 hours after

Baltimore, Maryland 21215-0036

show

28a-f

items 23a or

'natural", or

traumatic event, the Medical

is marked other

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra

Examinations be notified at

sician and burial-trans ō ed by the detached sign be Be Completed page 2 should Certification: To after death filled in by the

<u>ک</u>

Medical

State Registrar Ade Isaac Ajayi,

31. Date filed (Month, CFP 2 1

requires that the death certificate be executed

or Attending Physician: The law

thin 24 hours a Hospital

Division of Vital Records, P.O. Box 68760

Cause (Disease or injury that initiated events resulting in death) Last	c	quence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1  Live birth 2 Feta 4 Pregnant at time of	al déath 3 □ E	ctopic pre			23	d. Date of delivery Month Day	Year	
Part II. Other significant conditions of	ontributing to death but not res	sulting in the unde	erlying cau	ise given in Part I.	23e. Did tob	acco use	e contribute to the caus	e of death?	
Anemia					1 ☐ Yes	5 2₹	No 3 ☐ Probably	4 Unkno	
Arteriovenous Mal	formation				24a. Was an autopsy perform 1 □ Yes 2	ed?	24b. Were autopsy find prior to completio death? 1 □ Yes 2 🗷 N	n of cause of	
25. Was case referred to medical examiner?					ath (Check only one	)			
1 ☐ Yes 21X No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 DOA	Other: 4X Nursing	Home 5 🗆 Resider	nce 6[	Other (Specify)		
27. Manner of Death 1  Natural 5  Pending 2  Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how				
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street fy)	, factory, c	actory, office 28f. Location (Stree City or Town, S			t and Number or Rural Route Number, tate)		
29a. Certifier 1X Certifying Ph (Check only one) 2  Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death or ation and/or inves	ccurred at	the time, date and place n my opinion, death occ	e, and due to the ca urred at the time, da	use(s) a te and p	and manner as stated. place, and due to the ca	iuse(s)	
29b. Signature and title of certifier			29c. l	License number	29	d. Date	signed (Month, Day, Ye	ear)	
· CC	xuz			5217		9/21	/2009		
30. Name and address of person who	completed cause of death (Iter	n 23a) (Type, Prir	nt)						

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Greenbelt Road M18 College Park, MD 20740

6201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Feddon Willie В. September 16, 2009 7:21 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 17024 Clear Creek Drive Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 XF 579-14-2359 Yrs 91 Director Oct. 19, 1917 Tennessee Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner mast be notified at Director 1 Tyes 2XX No Maryland Silver Spring Montgomery the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò death with 20905 USA 23a 17024 Clear Creek Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status be filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🛣 No Specify: 2 White Specify: 3x Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Giant Bakery 12 yrs. Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wi11 Minnie Hinton Lewis ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra Brenda F. Tyrrell / Grandaughter 2030 Rolling Knolls Court, Huntingtown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 XX Firial 2 ☐ Cremation 3 ☐ Removal from State 09/21/2009 4 Donation 

∫ Donation for □Other (Specify) Resurrection Cemetery Clinton, Maryland 22. Name and Address of Facility 21. Signature Inneral Service Licensee George P. Kalas Funeral Home PA alas 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** END STAGE DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): g physician and as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as the aftending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) P.0. ed by the 1 ☐ Yes 2 X Xio 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Failure to Thrive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XX Unknown Completed Osteroporosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 The perform certificate Chronic Back Pain 1 ☐ Yes 2XIXINo 2 ∏ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2XXNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 1 X Matural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide **Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0055522 September 17, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert H. Gerard MD 1500 Forest Glen Road Silver Spring, Maryland 20910 SEP 2 1 2009

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State Registrar